

RELATIONS BETWEEN CHILD MOLESTERS' SELF-PERCEPTIONS AND
TREATMENT ENGAGEMENT

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Researchers emphasize the role of cognitions in sex offenders' molesting behaviors. Although cognitions are important, little research has examined child molesters' thoughts about themselves in relation to their engagement in treatment. In this study, the NEO-Personality Inventory (NEO-PI-R) was administered to 67 child molesters. Child sexual offenders rated themselves and their view of a typical child molester using two NEO-PI-R versions. The degree to which child sex offenders identify themselves with their view of a typical child molester, and this agreement's relation with engagement in treatment, were investigated. The view that child sex offenders hold about themselves in relation to a typical child molester showed no relation to treatment engagement or length of time in treatment. However, this self-perception was related to the number of children abused.

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CHAPTER 1

INTRODUCTION

Self-perceptions can be very useful in understanding and implementing appropriate treatment for sexual offenders. Several researchers have investigated sexual offenders' perceptions in relation to self-concept, relationships, personality, and perceptions of others (Frisbie, Vanasek, & Dingman, 1967; Horley & Quinsey, 1994; Horley, Quinsey, & Jones, 1997; Smallbone & Dadds, 1998; Ward, McCormack & Hudson, 1997). However, little research has investigated the self-perceptions of sex offenders' personality traits in relation to treatment engagement. Personality factors are important phenomena to study because they tend to reflect how an individual is thinking, feeling, and behaving (American Psychiatric Association [APA], 1994). Moreover, it may be that sexual offenders are more engaged in treatment if they identify themselves as similar to a typical sexual offender. This may occur because they are taking on the responsibility for their actions and will, therefore, be motivated to change their behaviors. Therefore, examining child molesters' self-perceptions in relation to personality factors and treatment engagement appears to be an important area to study with potential implications for clinical practice.

Child sexual abuse laws are found in all states and child sexual offenses encompass a variety of sexual and non-sexual acts (Conte, 1986; Faller, 1998; Gil, 1995; Gil & Bodmer-Turner, 1994). People who perpetrate sexual acts against minors are often

called child molesters and are sometimes labeled as pedophiles (Becker, 1994; Prentky & Foley, 1999). Research shows that many individuals commit sexual crimes against minors. Moreover, many of these offenders are living in the general population. In addition, child molesters tend to have more than one victim and have moderately high rates of recidivism (Greenfeld, 1997). For this reason, laypersons are often opposed to rehabilitation and believe that sex offender treatment will be ineffective (Association for the Treatment of Sexual Abusers [ATSA], 1996). However, research has shown that treatment is effective in reducing recidivism rates (Alexander, 1999; ATSA, 1996; Barbaree & Marshall, 1988; Dwyer, 1997; Grossman, Martis, & Fitchner, 1999; Hall, 1995; Hanson, 1997; Maletzky, 1991). Because treatment programs have had a positive impact in lowering the recidivism rate of sexual offenses, continuing to investigate factors that relate to treatment success remain important and worthwhile.

Currently, cognitive behavioral treatment is often considered the most effective treatment for child molesters (ATSA, 1996; Marques, Day, Nelson, & West, 1994; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Marshall & Pithers, 1994; Prentky, Knight, & Lee, 1997). Although cognitions are seen as important components of treatment, little research has investigated the relation between specific cognitive phenomena and treatment engagement. Researchers have noted that one way to investigate cognitions is to examine self-perceptions or views of oneself (Horley & Quinsey, 1994). Prior investigations that have examined sex offenders' self-perceptions not only have enhanced our knowledge about sexual offenders' positive and negative images of themselves, but also have assisted clinicians in targeting specific areas of treatment. One way to assess how an individual views himself or herself is through an

assessment of personality. However, the majority of research that has examined personality of sexual offenders has utilized inventories which examine psychopathological traits or personality disorders. In addition, most studies are of a descriptive nature, defining traits of sexual offenders without applications for treatment. One proposed model of “normal” personality is the Five Factor Model (FFM; Costa & Widiger, 1994). According to Costa and Widiger (1994), the FFM is the most adequate and comprehensive taxonomy for describing personality. The NEO Personality Inventory (NEO-PI-R) is an instrument designed to measure the FFM. Because the NEO-PI-R also has a parallel version, it allows for examination of self-perception in comparison to perception of others. The goal of this study, therefore, is to investigate the self-perceptions exhibited by sex offenders regarding their own personality via the FFM and their conception of the personality of a typical child molester; how these perceptions relate to their treatment engagement will be evaluated.

Child Sexual Abuse Laws

The first child sexual abuse reporting law was written in 1964 (Gil, 1983). At present, all states have laws that prohibit sexual contact between adults and children or adolescents. However, legal definitions found in state laws vary considerably from state to state (Conte, 1986). Although laws vary, there is general agreement that child sexual abuse entails the use of a minor (age dependent on state/county) for sexual activity. One prevalent definition of child sexual abuse is the exploitation of a child or adolescent under the age of 17 by an adult (or another child at least two years older than the victim) for the purpose of the offender’s own gratification.

Types of Sexual Abuse

A sexual offense against a child can encompass both physical and non-physical acts of sexual abuse. Non-physical sexual abuse may include the following activities: sexy talk (e.g., statements regarding the victims' sexual attributes or regarding sexual acts and other sexual comments), exposure (e.g., revealing sexual parts or masturbating in front of the victim), and voyeurism (e.g., observing the victim in a state of undress or in activities that provide the perpetrator with sexual gratification). Sexual exploitation is another form of non-contact sexual abuse which may include pornography (e.g., taking pictures of children or showing the victim pornographic pictures) or prostitution. Sexual abuse involving physical contact may constitute fondling of sexual body parts, oral-genital sex, frottage (e.g., rubbing genitals against the victims body or clothing), and digital, object, or genital sexual penetration into one of the victim's orifices (Faller, 1998; Gil, 1995; Gil & Bodmer-Turner, 1994). Individuals who commit these types of crimes against adults and/or children are called sex offenders. Those who perpetrate these types of sexual acts primarily against children are more specifically referred to as child sex offenders or child molesters (Becker, 1994).

Child Molestation

The term child molester is not a clinical term. It is a popular term used to describe someone who has had sexual contact with a child (Cook & Howells, 1981; Knight, Carter, & Prentky, 1989). According to Becker (1994), child molesters make up a significant portion of sex offenders. They have various motivations for perpetrating sexual acts against minors and engage in a wide variety of sexual activities (Becker, 1994; Prentky et al., 1997). Individuals who molest children may engage in incest (e.g.,

sexual acts between family members other than husband and wife), extrafamilial sexual abuse (sexual acts between non-family members), or both (Prentky & Foley, 1999). The term pedophile is commonly used to describe individuals who sexually molest children exclusively. The term pedophile, however, is not synonymous with the term child molester; it is simply a subcategory (Prentky & Foley, 1999).

Pedophilia

Pedophile is a clinical term used to describe an individual who has a sexual attraction or sexual preferences for prepubescent children (Friedman, 1991). The DSM-IV (APA, 1994) reserves the term pedophilia for sexual activity with a prepubescent child, generally age 13 years or younger. According to the DSM-IV, the individual with pedophilia must be at least 16 years of age and at least 5 years older than his/her victim. Clinical judgment regarding the above criteria is used on a case-by-case basis with perpetrators who are in late adolescence. In order to receive a clinical diagnosis of pedophilia, one must experience recurrent, intense sexually arousing fantasies, and sexual urges directed at prepubescent children over a period of at least six months; or engage in behaviors with a prepubescent child or children over a period of at least six months. As a result of their fantasies, urges, or behaviors, individuals must also experience significant distress or impairment in important areas of functioning in order to be diagnosed. The DSM-IV indicates that pedophiles may be sexually attracted only to children or to both adults and children. Some researchers note that pedophiles represent the largest proportion of child sexual abusers (Engel, 1989).

Crimes Involving Children

One of the most despised crimes in our society is the sexual abuse of children (Prentky et al., 1997). According to the U.S. Department of Justice Bureau of Justice Statistics (Greenfeld, 1997), a large percentage of rape and sexual assault crimes involve children. In a report drawing on more than two dozen statistical databases maintained by the BJS and the Uniform Crime Reporting program of the FBI, rape and sexual assault offenders constitute 4.7% of the almost 5 million convicted offenders serving time in federal or state prisons, in jails, or on probation and parole (Greenfeld, 1997). In 1994, 9.7% (88,100) of those residing in state prisons nationwide were sex offenders (e.g., convicted of rape or sexual assault). Convicted rape and sexual assault offenders serving time in state prisons reported that two-thirds of their victims were under the age of 18 (Greenfeld, 1997). Fifty-eight percent of those offenders said their victims were aged 12 or younger (Greenfeld, 1997). Therefore, the majority of sex offenders in state prisons are child molesters. However, most sex offenders, including those convicted, live in the community, not in correctional facilities.

Sexual Offenders in Communities

Greenfeld (1997) noted that on a given day, there are approximately 234,000 offenders convicted of rape or sexual assault under the care, custody, or control of corrections agencies. The 1997 BJS report estimated that approximately 100,000 offenders convicted of rape or sexual assault resided in local jail or state or federal prisons (Greenfeld, 1997). An estimated 134,000 convicted offenders (60%) were under conditional supervision in the community, such as parole (following imprisonment) or probation (Greenfeld, 1997). Therefore, the majority of sex offenders are not incarcerated

or institutionalized. Further, among those sent to jail or prison, the length of time spent in correctional facilities is relatively short compared to the length of the actual sentences.

Serving Sentences

Individuals convicted of sexual assault have been admitted to prison with sentences averaging between 8 and 9 years (Greenfeld, 1997). Between 1985 and 1993, the average sentence individuals departing from prison received for a sexual assault was approximately 6.5 years (Greenfeld, 1997). The average time they served for their offense, however, was between two and three years (Greenfeld, 1997). According to Greenfeld (1997), released sexual assaulters in 1985 had served approximately 34% of their sentences prior to discharge whereas sexual assaulters released in 1993 had served just over 41% of their sentences. More noteworthy, however, is that many sex offenders revert to earlier patterns of behavior after release from prison (Furby, Weinrott, & Blackshaw, 1989).

Recidivism Rates

Individuals who were incarcerated for committing sexual assault were 7.5 times as likely as those convicted of other crimes to be re-arrested for a new sexual assault (Greenfeld, 1997). Re-offense rates for untreated sex offenders who primarily target children range from 10% to 40% (ATSA, 1996). The majority of literature cites rates of at least 20% or above. Sexual re-offense rates for treated sexual offenders has been cited in the literature between 10% and 20% (Alexander, 1999; Hason & Bussiere, 1996; Maletzky, 1991). Most of the rates are documented toward the lower end of this range.

In an examination of 79 studies of 10,988 offenders, Alexander (1999) found that when offenders were followed for as long as ten years, the treatment effect weakened

over time, but even in the tenth year, treated offenders reoffended less than untreated men. Nevertheless, recidivism rates for sex offenders, in contrast to other types of offenders, do not appear to decline significantly as the offender ages. For instance, child abusers have been known to reoffend as late as 20 years following release into the community (Prentky et al., 1997). Hanson and colleagues (1992) investigated the recidivism rates of 126 treated child molesters. All men were sentenced between three and 24 months for a sexual offense against a child and were treated between 1965 and 1973. Recidivism was defined as a reconviction for sexual and/or violent offense. The greatest risk period for reoffending was the first five to ten years. Moreover, child molesters were at significant risk for re-offending throughout their entire life. Fifty percent of the sample was eventually reconvicted, with 23% of the recidivists being reconvicted more than 10 years after they were released. It is important to note that estimates regarding re-offense rates do not take into consideration those who re-offend without being caught.

Under-reporting of crimes

Some researchers assert that sexual assaulters, particularly those who assault children, often are never reported to the police (Abel, Mittelman, Cunningham-Rathner, Rouleau, & Murphy, 1987). Many experts believe that sexual abuse is the most under-reported form of child maltreatment (National Clearinghouse on Child Abuse and Neglect, 1988). As a result, Prentky and colleagues (1997) note that it is difficult to ascertain the frequency of child sexual abuse and the size of offender populations. Thus, attempts to quantify recidivism rates likely under-estimate the actual re-offense patterns (Furby et al., 1989).

Child Molesters in the Community

In order to more accurately estimate the number of child sex offenders residing in the general population, Finkelhor and Lewis (1988) conducted a random nationwide telephone survey. They found that up to 17% of the male population admitted to having molested a child. Abel and colleagues (1987) examined the sexual behaviors of 561 non-incarcerated paraphiliacs (i.e., preference for the use of a nonhuman object for sexual arousal, repetitive sexual activity with humans involving real or simulated suffering or humiliation, or repetitive sexual activity with non-consenting partners) who were voluntarily seeking treatment or assessment. Of the total number of paraphilic acts that Abel and his colleagues (1987) examined, 21.9% involved the molestation of a child. As mentioned earlier, child sex offenders have a higher likelihood of re-offending if they have not been provided with adequate treatment. Therefore, investigating factors related to the treatment of child molesters is necessary in order to increase public safety and prevent further re-offense.

Treatment Concerns

Generally, the anger and animosity that individuals in American society have toward child molesters inhibits interest in and support for sex offender treatment (ATSA, 1996). Additionally, many believe that child sexual offenders are untreatable. This belief is due, in part, to public awareness of moderately high recidivism rates and multiple victims, many whom are repeatedly perpetrated against. Maltzky (1991) analyzed data from 5,000 treated sexual offenders between 1971 and 1990. Out of the total sample, 3,720 were considered pedophiles. Of the 2,865 heterosexual pedophiles, 34.8% reported having more than one victim. Of the 855 homosexual pedophiles, 51.1% reported having

more than one victim. Abel and colleagues (1987) found that nonincestuous pedophiles who were not under court order to receive evaluation or treatment reported an average of 20 female victims and 150 male victims. Although in this study, the median number children abused ranged from 1.3 for nonincestuous female targets to 4.4 nonincestuous male targets, the means indicate that some individuals had extensive numbers of victims. When Abel examined incestuous pedophiles, he found the average number of children abused with both male and female victims was between 1 and 2. However, Abel also found that incestuous pedophiles repeatedly molest the same child, from an average of 36.7 molestations per boy victim to 45.2 molestations per girl victim. Although these statistics are striking, research has demonstrated that “with specialized treatment and adequate support groups, a child molester who accepts full accountability for his or her crime can learn to control his or her abusive behavior” so that he or she will not re-offend (Stop It Now, 1999).

Effectiveness of Treatment

The overall effectiveness of treatment for reducing recidivism has been a controversial topic (Hanson, Steffy, & Gauthier, 1992). Furby, Weinrott, and Blackshaw (1989) reviewed 42 published and unpublished sex-offender recidivism studies (30 treatment outcome studies and 12 studies of untreated offenders) with sample sizes over 10 which totaled to approximately 7,000 participants. The majority of studies were published before 1978. After noting the numerous methodological challenges and variable results, the authors concluded that there was no evidence that clinical treatment reduced rates of sex re-offenses in general. Additionally, there was no data for assessing whether it would be differentially effective for different types of offenders. Marshall and

Pithers (1994) outlined problems with the Furby analysis. For instance, more than half of the data came from participants at programs which are now closed and/or whose treatment methods are currently considered outdated. In addition, the samples overlapped in at least one-third of the studies reviewed which biased the results against positive findings.

Rice, Quinsey, and Harris, (1991) examined 136 extrafamilial child molesters, many of whom had a severe psychiatric disorder, in a maximum security prison. Recidivism was measured in terms of arrest or conviction of a sex crime, violent crime or any crime, based on police and parole reports. Rice and colleagues found that treated and nontreated participants were equally likely to recidivate. Grossman and colleagues (1999) countered the validity of Rice's findings by stating that their treatment program was brief, did not offer modern innovations, such as cognitive techniques, and contained a large percentage of people with poor prognosis.

Despite these studies that did not find treatment to be effective, recent studies have indicated that there has been a reduction in recidivism for sexual offenders receiving treatment (Alexander, 1999; ATSA, 1996; Dwyer, 1997; Grossman, Martis, and Fitchner, 1999; Hall, 1995; Maletzky, 1991). Grossman, Martis, and Fitchner (1999) presented an analysis of Medline literature from 1970 to 1998 including key reviews and papers that presented data on outcomes for sex offenders in treatment programs. Of the four studies that examined treated and untreated child molesters from institutional settings, two reported lower recidivism rates for treated individuals and two showed no difference. One of the two that showed no difference was the Rice, Quinsey, and Harris study (1991) discussed above. The other was a study that used a follow-up period of 19-28 years.

Grossman and colleagues suggested that the lack of efficacy in this study seems to be due to the extensive length of the follow-up period. In the two studies that demonstrated treatment effectiveness for institutionalized offenders, treated child molesters had a re-arrest rate of between 6% and 8%, whereas untreated molesters had a re-arrest rate of between 13% and 33%. Among outpatient treatment programs, results demonstrated that treated child molesters, in all three studies, had lower recidivism rates than their untreated counterparts. Recidivism was defined in terms of charges, re-arrest, or self-report. Recidivism rates for treated offenders ranged from 6% to 13.2% and recidivism rates for untreated offenders were approximately 35%.

Alexander (1999) analyzed 79 sexual offender treatment outcome studies that totaled to approximately 11,000 offenders from 1961 to 1996, with the majority of studies in the latter years. Child molesters accounted for 2,137 individuals. In her analysis, Alexander defined recidivism as the number of participants who were rearrested for a new sexual offense. The longest follow-up period for child molesters was five years. Alexander found that treated child molesters had lower recidivism rates than untreated offenders. Treated child molesters reoffended at a rate of 14.4%, whereas 25.8% of untreated child molesters reoffended. In her review, Alexander did not include multiple studies with overlapping participants. Additionally, she only reported studies that included clear outcome data consisting of samples sizes greater than ten. Unfortunately, Alexander did not provide specification as to how the data on untreated offenders in different studies were gathered. Although these results are optimistic, Alexander was unable to utilize several studies with unclear outcome data. She also eliminated participants who dropped out or were terminated from treatment because there was a lack

of consistency with which data on these participants were reported. Because data could have been skewed by these methods, caution must be taken when interpreting these results.

Hall (1995) conducted the first meta-analysis of 12 studies in the literature that were published since 1988, with a total sample size of 1313 offenders. Hall defined recidivism as sexually aggressive behavior, which resulted in official legal charges after one's treatment period; however, sexually aggressive behavior was not defined. Ten of the 12 studies included men participants who had committed sexual offenses against children. Half of the studies were of outpatients and the other half involved institutionalized participants. In the studies that Hall reviewed, the mean length of treatment was 18.5 months and the mean follow-up period was 6.85 years. Hall discovered that the overall recidivism rate for treated sexual offenders was 19%, whereas for untreated offenders it was 27%. Thus, treatment appeared successful in reducing recidivism. However, Hall found that treatment effect sizes across studies were significantly heterogeneous. Among the studies used for analysis, only a few performed random assignment. However, Hall noted that orthogonal contrasts between studies in which random versus nonrandom assignment to treatment was used were not significant. In addition, it is also important to note that in his analysis, Hall excluded the most pathological participants. (i.e., extensive offense history, psychotic, organic brain dysfunction, denied offenses, management problem in prison, withdrawal from treatment program). Although a rationale for this was not stated, including these participants may have reduced the effectiveness of treatment. In addition, Hall's use of official recidivism

data may have underestimated the actual incidence of sexually aggressive behavior. In turn, both of these designs may have overestimated the effectiveness of treatment.

Barbaree and Marshall (1988) followed 68 treated and 58 untreated child molesters referred to the Kingston Sexual Behavior Clinic for assessment of their sexual functioning. The untreated offenders did not receive treatment because they either lived too far away or they were incarcerated for too short a period. Recidivism was defined as the number of sexual reoffenses the men had committed. The average follow-up period lasted four years. All participants' official records of criminal charges and convictions, police and child protective agency files, and self-report by the men and their families were used to determine if they had reoffended. Of the men who admitted guilt and underwent treatment, 13% reoffended. Of the men who admitted guilt but did not undergo treatment, 34% reoffended. However, as with other studies, using official records of charges and convictions may have underestimated actual offense rates. It appeared that self-report was attempted to balance this bias, but only 21% of the offenders responded when asked to self-report their relapses. Furthermore, offenders were found to deny their relapse behavior; one man admitted to his relapse and three others who denied having any subsequent relapses had official records of relapse. Nevertheless, this study had the benefit of analyzing child molesters with stringent criteria (e.g., all men molested a child under the age of 16 when he was at least 5 years older than the child) and used a sound control group (e.g., men who had been interested in treatment and admitted their guilt, but did not receive treatment due to incarceration, distance to treatment site, etc.).

Between 1973 and 1990, Maletzky (1991) followed 5,000 offenders (which included approximately 3,700 pedophiles) who were treated with the behavioral techniques of aversive conditioning in a sexual abuse clinic in the northwestern United States. Patients were referred to the clinic through both voluntary (i.e., referral by therapist, spouse, relative, friend, or self-referral) and involuntary (i.e., lawyers, probation, parole, police, children's services divisions) means. Only one quarter of the patients were voluntarily referred. Most were referred through the legal system, mostly during the period between arrest or arraignment and pleading or sentencing. Some men were followed as long as 17 years post-treatment. Success was defined as no re-arrests, self report of no maladaptive sexual behaviors, ratings of patient behaviors by significant others regarding how well the patient has progressed and how well he was following through with his treatment/homework, and reduced deviant arousal maintained post-treatment as verified on penile plethysmograph. A penile plethysmograph is a device used to measure sexual arousal through erectile responses to age-appropriate, consenting, and deviant sexual stimulus material. Results indicated that success was achieved with 94.7% of heterosexual pedophiles and 86.4% of homosexual pedophiles. Although these results seem especially promising, the study is not without methodological flaws. For example, follow-up data were gathered for only 75% of the original 5000 patients. In addition, the majority of participants were followed for only three years. There was no control group and the investigation was not double blind. Further, because some participants were not treated identically (i.e., some were treated as routine clinic patients and diverse techniques were employed based on individual needs), assessment techniques

were partially subjective. Nevertheless, the study's large sample size promotes confidence in the efficacy of treatment for outpatient child sex offenders.

As shown above, child molesters have a moderate tendency to recidivate after being treated. However, various investigators have shown that sex offender treatment appears to be a powerful component in the reduction of recidivism and prevention of future sex offenses.

Treatment Techniques

Sex offender treatment programs, especially those that target child molesters, employ a wide variety of treatment techniques. For instance, treatments may include components that focus on: education (e.g., social skills training, anger management), pharmacological treatment (e.g., reducing sexual arousability and the frequency of deviant sexual fantasies through the use of antiandrogen and antidepressant medication), group therapy, behavioral reconditioning, cognitive restructuring, family work, or relapse prevention. These approaches are not mutually exclusive and, at the present time, treatment programs that employ combinations of components are well-regarded (Prentky, et al., 1997).

Cognitive-Behavioral Therapy

At present, the most effective and most widespread intervention seems to be cognitive behavior therapy and, when appropriate, medication (ATSA, 1996; Hall, 1995; Marques, Day, Nelson, & West, 1994; Marshall, Jones, Ward, Johnston, & Barbaree, 1991; Marshall & Pithers, 1994; Prentky, et al., 1997). The cognitive component entails teaching offenders how to recognize and change their patterns of thinking. The behavioral element focuses on teaching offenders specific means to control or modify

their deviant or inappropriate impulses, behavior, arousal, and fantasies (Becker, 1994; Beech and Fordham, 1997). Cognitive behavioral approaches to treatment assume that underlying belief systems serve to initiate and propagate sexually assaultive behavior (Abel, Becker, Cunningham-Rathner, 1984; Murphey, 1990; Stermac & Segal, 1989). Consequently, clinicians view sexual offenders' cognitions to be genuine indicators of treatment motivation and progress (Murphy, 1990; Pithers, 1994; Pollack & Hashmall, 1991).

The Importance of Cognitions

Johnston and Ward (1996) argue that in order to have successful treatment programs, the sexual offenders' cognitive processes must be understood. Langevin and Lang (1985) suggest that the primary goal of sex offender treatment should involve restructuring the rationalizations and cognitive distortions that sexual offenders hold regarding their sexual involvement with children. Cognitive distortions, in this context, are thinking errors or irrational thoughts that sex offenders use to justify and minimize their sexually abusive behavior. In essence, they are self-generated excuses for one's relapse patterns. Yochelson and Samenow (1977) claim that the only effective way to prevent a chronic offender from committing further offenses is to modify his/her thinking patterns.

Cognitions and Treatment Progress

Pithers (1994) investigated changes in incarcerated pedophiles' and rapists' cognitive distortions after they participated in victim empathy training. He found a significant decrease in the endorsement of cognitive distortions about both child molestation and rape following treatment. However, a drawback to this study is that

Pithers had a small sample size of only 20 participants of which only 10 were pedophiles. In addition, the instruments used to measure cognitive distortions were face-valid and may have promoted participants to respond in a socially desirable way.

Barbaree (1991) evaluated the degree of denial and minimization of approximately 41 incarcerated child molesters and rapists using the Multiphasic Sex Inventory (MSI; Nichols & Molinder, 1984) and the Denial and Minimization Checklist. The Denial and Minimization Checklist had no stated reliability or validity estimates. Over half of the participants were rapists. Barbaree's treatment procedures were similar to those used by Marshall (1994). In Barbaree's program, each offender disclosed his offense to other sexual offenders and a treatment provider. Following the disclosure, the group therapist gave an account of the official version of the offense based on the police reports and victim statements. Then, members in the treatment group were asked to list the discrepancies between the inmate's version and the official version. The offender was asked to account for the discrepancies, while the group was encouraged to challenge the offender on his account of the discrepancies. Work on each inmate extended over several hours of group therapy, with a typical duration of six hours. Although a significant proportion of child molesters continued to minimize their behavior from pre-to post-treatment, Barbaree noted that the degree of minimization decreased. He found significant reductions on 5 of the 6 subscales of the MSI with the most salient being reductions in Justifications. A limitation of this study is that Barbaree only examined incarcerated offenders. Institutionalized offenders have been shown to make less progress in treatment than individuals in outpatient therapy (Hall, 1995). Thus, stronger effects may occur when non-incarcerated patients undergo the same type of treatment. In

addition, the typical duration for treatment in this study was short, yet participants still benefited. It is likely that with extended treatment, minimization will decrease even more.

Marshall (1994) examined the degree of denial and minimization in 81 incarcerated incest offenders, nonfamilial child molesters, and rapists who resided in a minimum-security Canadian penitentiary. Fifteen of the participants were rapists and 66 were child molesters. According to Marshall, participants in this investigation were less dangerous than in the sample collected by Barbaree (1991). In this study, offenders were treated for approximately six hours per week for 12 weeks. In treatment, each offender disclosed the nature of his offenses. Following each disclosure, group members challenged the offender with questions regarding his report. Then, the therapist read a summary of the victim's account and the official version of the offense. Offenders were repeatedly challenged and were to repeat their disclosures until their narratives were acceptable by all group members. The degree of minimization was rated both prior to and following treatment. Marshall concluded that all three groups benefited equally well from this program. They all exhibited significantly less denial and minimization from pre-treatment to post-treatment. This study may have demonstrated greater success rates than the one conducted by Barbaree (1991) because Marshall studied offenders in a minimum-security facility and examined a greater proportion of child molesters. Alexander (1999) demonstrated that treatment is more effective with child molesters compared with rapists. Similarly, Pithers (1994) found that pedophiles exhibit greater empathy than rapists both before and after treatment.

In sum, researchers and clinicians in the sexual abuse field consider cognitions to be a focus of clinical attention in the treatment of sexual offenders. However, research

has been limited in scope, looking primarily at cognitive distortions, minimization, and denial. Further, commonly used measures that assess cognitions, such as the Abel and Becker Cognitions Scale (1994) and the Bumby Cognitive Distortions Scales (1996) are face-valid. This has made it easy for sexual offenders to feign their true thoughts and respond in a socially desirable manner. A goal of this study, therefore, is to broaden the study of cognitions and more subtly investigate their nature as they relate to treatment engagement.

Horley and Quinsey (1994) note that two approaches are available for assessing the cognitions of child molesters. First, researchers can investigate distinctive cognitions or particular beliefs that may lead to deviant behavior. Second, investigators may conduct a less focused examination of molesters' thoughts about themselves and others. The present study is more concerned with the second approach, focusing on child molesters' general perceptions.

Research on Sex Offenders' Perceptions

Frisbie, Vanasek, and Dingman (1967) were among the first investigators to examine the self-perceptions of sexual offenders. In their study, Frisbie and colleagues examined over 200 incarcerated and community-based child molesters' views of their actual and ideal selves using the semantic differential (Osgood, Suci, & Tannenbaum, 1957). The semantic differential is a series of rating scales that represent extreme ends of bipolar variables using pairs of adjectives. Participants in this study were presented a graphic sheet containing alternative type ratings for adjectives. The participants were instructed to rate themselves and how they ought to be on the continuous line between each adjective pair. After testing, the graphic rating scale was transformed into

millimeters and distances were measured on the scales. Words that were evaluative and had some connotation about the inner self or one's self-image did not yield discrepancies between ratings of the real and ideal self. Words that were descriptive but nonevaluative (i.e., straightforward adjective pairs) gave rise to large differences between ratings of the ideal self and the real self. There were few differences between child molesters in the community and child molesters in institutions. Overall, community child molesters reported more similarity than incarcerated offenders between their actual versus their ideal selves. Frisbie and colleagues theorized that those individuals who report minimal differences between the actual and ideal selves for the items describing basic personality components are less amenable to change and more recidivistic than those who perceive greater differences between the way they are and the way they should be. Since this research was published, investigators have continued to study self-perceptions of sex offenders.

In 1994, Horley and Quinsey examined 57 incarcerated child molesters' thoughts about themselves and others using a specially constructed version of the semantic differential as a measure of attitude. Child molesters were not indicated as having received any psychological treatment. Child molesters' thoughts were compared with the cognitions of 50 incarcerated non-sexual offenders and 30 nonincarcerated men recruited from the community. Community participants were recruited through a newspaper advertisement requesting persons to participate for a study on social perceptions and personal attitudes. To measure these constructs, participants were given a piece of paper with bipolar scales which were placed at opposite sides of a page with seven spaces between them. Participants were to rate different stimuli (e.g., self, ideal self, etc.,) by

marking an X over the appropriate space. Child molesters described themselves, relative to incarcerated non-sexual offenders, as less sexually attractive (i.e., less seductive and less sexy). Relative to the community participants, child molesters saw themselves as less clean. Relative to both community participants and nonsexual incarcerated offenders, child molesters saw themselves as less soft and less erotic. Child molesters saw their ideal selves as less seductive than incarcerated nonmolesters. Compared to the community sample, child molesters saw their ideal selves as less spontaneous and less soft. Molesters also described their ideal selves as more submissive, less erotic, and less big than both community participants and nonsexual incest offenders.

Horley, Quinsey, and Jones (1997) re-examined differences between incarcerated child molesters' and incarcerated non-molesters' (i.e., those with person-related but non-sexual offenses) perceptions of themselves, children, and adults, utilizing both the semantic differential and repertory grid. A repertory grid is an assessment device that allows respondents to list the personal constructs that they use to classify particular people or events. The repertory grid in this study used the same concepts (i.e., self, ideal self, etc.) in the semantic differential. Elements to be compared were randomly selected. The investigators once again revealed that molesters described themselves as physically and sexually less attractive. Molesters also described their ideal selves as less seductive, less beautiful, less erotic, and less sexy than non-molesters. They also found women to be less physically and sexually appealing. These conclusions confirmed Horley and Quinsey's investigations. Because these two investigations used a non-threatening, conveniently self-administered, and relatively ambiguous assessment tool, more confidence can be placed in the reliability and accuracy of responses. However, the

authors caution that the negative ratings of these offenders may be due to offenders' low self-esteem or may be a result of incarceration and lack of freedom. Conversely, presenting oneself less favorably may also be an attempt to gain sympathy and support from one's treatment provider. Nevertheless, the above findings have important implications for therapy.

Ward, McCormack, et al. (1997) investigated the perceptions of recent adult intimate relationships of 55 child molesters, 30 rapists, 32 violent non-sexual offenders, and 30 offenders without a history of violence or sexual deviance. All participants resided in a medium security prison in New Zealand and none had undergone psychological treatment at the time of the study. Each of the participants completed a set of questionnaires and was also interviewed about his current or most recent adult romantic relationship. The questionnaires were concerned with attachment style, attitudes toward women, loneliness, and intimacy. Ward and colleagues found no clear-cut distinctions between sex offenders and other offenders in relation to intimacy deficits. Child molesters and non-violent offenders were found to have more committed and more favorable evaluations of their current relationships when compared with rapists. However, in their relationships, child molesters had lower levels of self-disclosure, less expression of affection, less support to their partner, less empathy, and less well developed skills for conflict resolution than did the nonviolent offenders. On the above dimensions, child molesters did not score significantly different from the other tested groups. Child molesters were significantly less sexually satisfied than any other group and were the most sensitive to rejection. These are all features which are likely to lead to lower relationship satisfaction and lower levels of intimacy. Thus, the authors concluded

that among child molesters, there was a greater degree of impairment in relationships. In general, child molesters tended to have more negative views of themselves than other groups. This was evident from their greater sensitivity to rejection and tendency toward fearful or preoccupied attachment styles, both of which are characterized by a negative view of the self. Overall, Ward and colleagues concluded that sex offenders have numerous intimacy deficits that create difficulties in romantic relationships.

Smallbone and Dadds (1998) gathered data from 32 incarcerated child molesters (incest and non-incest), 16 rapists, and 16 property offenders without a history of sexual or violent offenses from a correctional facility in Australia. In addition, 16 male custodial correctional officers without any known criminal history were recruited as a non-offending comparison group. Subgroups were compared on self-report measures of childhood maternal and paternal attachment and adult attachment. Sex offenders as a whole reported significantly less secure childhood maternal, paternal, and adult attachment than did non-offenders. Sex offenders also reported significantly less secure maternal attachment than did the property offenders. Among the sex offenders, intrafamilial child molesters tended to have anxious-avoidant mothers, whereas rapists tended to have avoidant and abusive fathers. There were no distinguishing features of the extrafamilial child molesters. It is important to note that in this study, data were collected from fewer than 20 individuals in each of the five groups. In addition, the fact that these offenders were incarcerated suggests that they may have had more severe difficulties, especially in their family history, than individuals who were not sent to prison. However, these results may actually under-estimate the amount of difficulty in attachment relationships because half of the rapists who were recruited did not wish to participate

due to the nature of the study. According to the authors, some of the individuals who declined stated that their paternal relationships were too distressing to reflect on. Moreover, it is difficult to ensure accuracy in responding when the study is retrospective in nature and concerns potentially troubling material. Even though these results may under-estimate the gravity of poor relationships, they still have important and useful implications for treatment.

Weeks, Pelletier, and Beaudette (1995) asked 82 front-line officers from two medium security federal institutions to rate their perceptions of sex offenders against children, sex offenders against women, and non-sex offenders using a perceptions scale that consisted of 19 bipolar dimensions arranged in a semantic differential format similar to that originally developed by Osgood and colleagues. They were also given an attitudinal questionnaire to complete. Sex offenders were perceived as being more dangerous, harmful, violent, tense, bad, unpredictable, mysterious, unchangeable, aggressive, weak, irrational, and afraid compared with non-sex offenders. Sex offenders against children were rated as significantly more immoral and mentally ill than non-sex offenders. This is consistent with the commonly held belief that the behavior of sex offenders is “sick.” In general, the correctional officers in this study openly endorsed the general social stigmas and myths surrounding the personality characteristics of sex offenders.

From studying offenders’ self-perceptions, investigators have been able to suggest specific areas that professionals working with sexual offenders should target, such as improving self-perceived attractiveness, working on problematic relationship issues, and increasing self-esteem. Thus, the perceptions of sexual offenders prove to be useful for

understanding sexual offenders' cognitions and improving treatment techniques. However, an individual's perception of self may be a reflection of personality. For example, perceptions of intimacy deficits may be attributed to an introverted personality pattern. Likewise, perceiving oneself as spontaneous may reflect personality traits that reflect Openness to Experience. Therefore, a more broad investigation of sexual offenders' perceptions would entail investigating cognitions related to personality patterns.

Personality Disorders

Lehne (1994) notes that the research literature on personality variables and sexual offenders has most frequently used the Minnesota Multiphasic Inventory (MMPI) or, occasionally, the Millon Clinical Multiaxial Inventory. However, these instruments are better measures of psychopathology than personality. Therefore, they may not be the most appropriate instrument to employ in assessing personality (Levin & Stava, 1987). Moreover, studies have not found any clear association between personality disorders and sex offenders. Lehne (1994) suggests that future research should focus more on personality dispositions to provide information that is useful in understanding clients and their rehabilitation planning.

Personality Traits

The DSM-IV (APA, 1994) explicitly defines personality traits as "enduring patterns of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts" (p.630). Traits reflect relatively enduring dispositions and are distinguished from states or moods, which are more transient (Costa & Widiger, 1994). Clark, Vorhies, and McEwen (1994) claim that

within the normal range, personality traits exhibit broad individual differences that represent a person's characteristic and adaptive style of thinking, feeling, and behaving. Lehne (1994) notes that researchers who have used less pathological personality inventories have used instruments such as the Edwards Personality Preference Schedule (Edwards, 1959), the Eysenck Personality Questionnaire (Eysenck & Eysenck, 1975), the Sixteen Personality Factor Questionnaire (Cattell, Eber, & Tatsuoka, 1979), the Comrey Personality Scale (Smukler & Schiebel, 1975), and the California Psychological Inventory (Forgac & Michaels, 1982) to study personality traits of sexual offenders. However, Costa and Widiger (1994) point out that all of the prior models can either be subsumed by the Five Factor Model (FFM) or interpreted in terms of it.

The Five Factor Model

Trull and McCrae (1994) endorsed that the FFM appears to provide the most comprehensive and normalized model of personality traits. The FFM asserts that there are five broad dimensions of personality: Neuroticism, Extraversion, Openness, Agreeableness, and Conscientiousness (Costa & Widiger, 1994). The broad or higher order dimensions of the FFM are defined by many more specific traits.

The NEO Personality Inventory

The NEO-PI-R (Costa & McCrae, 1992b) is an instrument designed to measure the FFM and includes facet scales demonstrating specific traits (Costa & Widiger, 1994). Lehne (1994) describes the NEO-PI-R as being a consistent indicator of personality. Lehne collected data using the NEO-PI from 99 men who were undergoing treatment at a sexual disorders clinic. All men were charged or convicted of at least one sexual offense. Lehne found that the sex offender's average scores were at least one-half standard

deviation higher than the normal population on Neuroticism. All other scores were in the normal range, corresponding to a typical normal population sample. Lehne (1994) found that sexual offenders agreed with descriptions of their personality from an assessment using the NEO-PI-R, even when some descriptions were quite negative. In all, the individuals rarely disagreed or objected to the characterization.

Briley (2000) evaluated 88 male sex offenders using the NEO-PI-R and the MMPI-2 at a court-mandated outpatient treatment program. Briley's participants were treated at one of the two data collection sites used in the current study (thus, some participants may have participated in both projects). Using a hierarchical cluster analysis, Briley discovered three clusters of sexual offenders: Antisocial, Unimpaired, and Impaired. The groups were then evaluated for differences in personality. Briley found that two of the three groups (i.e., Antisocial and Impaired) resulted in scores in the average range in all NEO-PI-R scales. The Impaired group, characterized by severe psychopathology and elevations on multiple MMPI scales, demonstrated mean scores in the high range on the Neuroticism scale and in the low range on both the Extraversion and Conscientiousness scales.

Although the NEO-PI-R has traditionally been used as a descriptive measure of an individual's personality, when coupled with a parallel version it can attempt to discover sexual offenders' perceptions of self versus other. In addition, using the NEO-PI-R in this manner would be non-threatening and ambiguous (in terms of social desirability). The synchrony between sexual offenders' views of themselves and others can then be related to their treatment engagement. Asynchronous views may have important implications for treatment.

Present Study

Purpose

No previous research has investigated the differences between sex offenders' perceptions of themselves and their perception of a typical sex offender in terms of personality constructs. Moreover, little has been done to examine personality identification with a typical sex offender (from the offender's perspective) as a guide in the treatment process. Looking at perceptions in this way may offer information that can predict who will be more engaged in treatment. In addition, it may offer implications for treatment. Therefore, the goal of the current study is to investigate the relation between self-perception versus perception of a typical sex offender and the offenders' treatment engagement. Specifically, child molesters' perceptions of themselves will be compared with their perceptions of a typical child molester. Then, the synchrony/asynchrony of these perceptions will be examined in relation to their treatment engagement.

Preliminary Scale Development

The Evaluation of the Offender (EVAL-O; see Appendix B) was developed in order to quantify treatment engagement. The instrument contains seventeen items. The first fifteen items measure engagement in treatment. Accordingly, overall treatment engagement is quantified by the sum of the first fifteen items on the EVAL-O. The last two items are not used as indicators of treatment engagement; they are included in the measure to test for potential halo effects. Items for this measure were selected based on the various ways treatment programs define progress. In addition, literature involving treatment behavior was reviewed. In general, behaviors that could be assessed with

relative ease by treatment providers were included. The alpha coefficient for items measuring treatment engagement was .94.

Hypotheses

First, individuals who sexually molest children are looked down upon by individuals in our society. Weeks, Pelletier, and Beaudette (1995) conducted a study that supported a negative view of child molesters. They found that front-line officers from federal institutions rated their perceptions of sex offenders against children as significantly more immoral and mentally ill than non-sex offenders. These findings were consistent with the commonly held belief that the behavior of sex offenders is “sick.” Therefore, it was predicted that on the NEO-PI-R, sex offenders will, on average, rate a typical child molester as possessing less desirable personality traits. Specifically, a typical child molester will be rated as high on Neuroticism, low in Openness to Experience, low in Conscientiousness, and low in Agreeableness. In addition, because there is a prevalent belief that men who sexually molest children are passive, lonely, and socially inadequate people (Levin & Stava, 1987), it was predicted that a typical child molester will be viewed as low in Extraversion.

Second, individuals who take more responsibility for their unlawful behavior and see themselves as being similar to their view of a typical sexual offender will be more likely to accept their need for help. Thus, they will view treatment in a positive light and will make notable treatment engagement. Frisbie, Vanasek, and Dingman (1967) were among the first investigators to examine the self-perceptions of sexual offenders. They suggested that individuals who reported minimal differences between their actual and ideal selves would be less amenable to change and more recidivistic than those who

perceived greater differences between the way they were and the way they should be. If individuals who have molested children are viewing themselves as ideal, it is safe to assume that they will be classifying themselves as very different from a typical child molester. Thus, consistent with Frisbie et. al., these offenders will be less amenable to change and will have poorer treatment engagement. However, if offenders view themselves as very different from their ideal self, they may be thinking of themselves as more similar to their conception of a typical molester. Given this, they will be more motivated to change and will be more engaged in treatment. Thus, it is predicted that on the NEO-PI-R, sexual offenders who view themselves as being similar to a typical sex offender will be more motivated to change and will exhibit more overall treatment engagement, as noted by their treatment providers.

Third, being in treatment for an extended period of time and having a lengthy sexual offense history will influence offenders to view themselves as being more similar to a typical child molester. Having perpetrated against a considerable number of children may make it difficult for individuals to deny that they are similar to those who commit child molestation. In addition, individuals who have been in treatment for a long time may also view themselves as being similar to a typical child molester because of expectations from their treatment providers. It was proposed that if self-identification with a typical child molester showed positive relation to number of years spent in treatment and the number of children molested, then these variables would be used as controls when testing other hypotheses.

Fourth, individuals who view themselves in a positive light by rating themselves as having desirable personality characteristics on the NEO-PI-R (e.g., low Neuroticism,

high Agreeableness, high Openness to Experience, high Extraversion, and high Conscientiousness) will behave in accordance with these views and portray a positive impression. Thus, treatment providers will rate these individuals positively on variables related to treatment engagement. Sexual offenders who display the most positive self-presentation on the NEO-PI-R will have good treatment attendance and will give appropriate excuses for missing sessions or arriving late. Displaying a positive self-presentation will also be associated with consistently completing homework assignments, behaving well in group, grasping the concepts presented in treatment, expressing remorse for the pain they caused their victim, demonstrating motivation for treatment and recovery, and believing they are cured. They also will show the most positive self-presentation when they admit to all offenses, take full responsibility for their crime, and not minimize their offenses.

Fifth, individuals who portray themselves in a positive light by endorsing socially desirable personality traits on the Paulhus Deception Scale will also portray a positive impression in treatment. As a result, therapists will be more likely to rate these individuals as being highly engaged in treatment. Thus, individuals who score high in social desirability on the Paulhus Deception Scale will have good treatment attendance and will give appropriate excuses for missing sessions or arriving late. Displaying a high level of social desirability will also be associated with satisfactorily completing homework assignments, behaving well in group, grasping the concepts presented in treatment, expressing remorse for the pain they caused their victim, demonstrating motivation for treatment and recovery, and believing they are cured. They also will endorse the most desirable responses on the Paulhus Deception when they admit to all

offenses, take full responsibility for their crime, and not minimize their offenses. Should a relation exist between the Paulhus Deception Scale and treatment engagement, this variable will be used as a control when analyzing the other hypotheses.

For easier reference hereafter, the hypotheses are enumerated below without elaboration:

1. On the NEO-PI-R, sex offenders will, on average, rate a typical child molester as high on Neuroticism, low in Extraversion, low in Openness to Experience, low in Conscientiousness, and low in Agreeableness.
2. On the NEO-PI-R, sexual offenders who view themselves as being similar to a typical sex offender will exhibit higher treatment engagement, as noted by their treatment providers.
3. Being in treatment for an extended period of time and having a lengthy sexual offense history will influence offenders to view themselves as being more similar to a typical child molester.
4. Individuals who view themselves in a positive light by rating themselves as having desirable personality characteristics on the NEO-PI-R (e.g., low Neuroticism, high Agreeableness, high Openness to Experience, high Extraversion, and high Conscientiousness) will be rated as more engaged in treatment.
5. Individuals who portray themselves in a positive light by endorsing socially desirable personality traits on the Paulhus Deception Scale will be rated as more engaged in treatment.

CHAPTER 2

METHOD

Participants

Adult male child molesters were recruited for participation from two sex offender outpatient treatment programs: The Professional Associates Counseling and Consultation Center (PACC) and the Psychotherapy Services and Yokefellows Center (PSYC), both in Fort Worth, Texas. A total of 69 child molesters participated in this study. In regard to specific sites, 45 men participated from PACC and 24 men participated from PSYC. Child molesters, in this study, were defined as men over 18 years of age who perpetrated a sexual offense against an individual 13 years of age or under. Participants in this study were required to have at least one child sexual offense. Women were excluded from this research because of lack of availability and limited generalizability. Finally, individuals who were unable to read at the necessary level required by the instruments were also eliminated from the study. At the Psychotherapy Services and Yokefellows Center, 11.2% of the participants who were recruited did not pass the reading test at the 6th grade level. At PACC, the number of individuals who did not pass the reading test at the required level was undetermined because a different system of record keeping was utilized. However, the individuals at both sites did not appear to be significantly different in terms of demographic information. Therefore, it is assumed that a similar percentage of people who were recruited at PACC were also ineligible due to reading ability. Of the 69

participants who participated in the study, one decided to withdraw from the study following the initial testing session and one was determined ineligible because he was not currently in treatment. Each participant signed an informed consent form (see Appendix C) if they chose to participate and was offered a copy to keep.

Materials

The NEO Personality Inventory-Revised (NEO-PI-R)

This measure, developed by Costa and McCrae (1992b), measures the five major dimensions or domains of personality and traits that define each domain. The five factors are: Neuroticism (N), Extraversion (E), Openness (O), Agreeableness (A), and Conscientiousness (C). Thirty facet scales offer a more fine-grained analysis by measuring specific traits within each of the five general domains.

Costa and McCrae (1992b) defined the factors of the FFM. The Neuroticism Factor is defined as tapping anxious, insecure, guilt-prone, and self-conscious traits. Individuals high on this factor are more likely to have irrational ideas. They are less able to control impulses, and have poor coping mechanisms. Individuals low in Neuroticism are defined as emotionally stable, calm, even-tempered, and relaxed. They are able to deal with stressful situations without becoming overly upset or rattled (Costa & Widiger, 1994).

The Extraversion Factor, one of the two primarily interpersonal factors, is defined as referring to talkative, sociable, fun-loving, and affectionate traits. Individuals high in Extraversion prefer involvement with large gatherings of people. They tend to be cheerful and enjoy excitement and stimulation. They are also active and assertive. Persons low in

Extraversion are reserved, independent, and even-paced. They tend to be sober, aloof, and quiet (Costa & Widiger, 1994).

The Openness to New Experience Factor taps nonconformity, imaginativeness, and the showing of broad interests. Openness is modestly related to education and measured intelligence. Individuals high in Openness are more willing to entertain novel ideas. Individuals low in Openness behave more conventionally and are more conservative. Their emotional experiences are less expressive than individuals high in this factor. They are dogmatic and rigid in their beliefs (Costa & Widiger, 1994).

The Agreeableness Factor refers to sympathetic, warm, trusting, and cooperative traits. The person high in Agreeableness is sympathetic and eager to help others. People who are high on Agreeableness tend to be good-natured, trusting, and forgiving. They tend to be responsive and empathetic and believe that most others want to and will behave in the same manner. Persons low in Agreeableness are egocentric, skeptical of others' intentions, and competitive. Those who are low on Agreeableness are referred to as antagonistic. They tend to be rude, cynical, irritable, and uncooperative.

The Conscientiousness Factor taps ethical, dependable, productive, and purposeful traits. Persons high in Conscientious have self-control and are able to organize, plan, and carry out tasks. They are purposeful, strong-willed, determined, and reliable. People who are high in Conscientiousness also tend to be hard working, self-directed, ambitious, and persevering. Individuals low in Conscientiousness are not necessarily lacking in moral principles, but are less rigorous in applying them. Individuals who are low on Conscientiousness tend to be aimless, unreliable, lazy, careless, lax, and hedonistic.

There are two versions of the NEO-PI-R: Form S for self-reports, and form R for observer ratings. Form S consists of 240 items answered on a 5-point Likert-type scale (“strongly disagree” to “strongly agree”). Form R is a companion instrument with 240 parallel items written in the third person. Form R can be used to obtain independent estimates of standing on the same five domains of personality. Both versions require 6th grade reading level.

According to Costa and McCrae (1992b) the NEO-PI-R self-report version has internal consistency ranges from .86 to .92 for the five factors. Test-retest reliability at a three-month interval ranged from .75 to .83 ($\underline{M} = .79$). Convergent validity between self-report and peer ratings tends to be modest, ranging from .30 to .48 (Mdn $\underline{r} = .38$). In assessing broad personality dimensions, however, correlations of this magnitude are typically found (Briley, 2000).

Evaluation of Offender (EVAL-O)

The EVAL-O, developed for the present study (see Appendix B), is a brief measure of treatment engagement for sexual offenders. The instrument contains seventeen items that best describe their clients. The first fifteen items measure engagement in treatment and the last two items measure general feelings about the client. Statements are rated on a 4-point Likert-type scale (“strongly disagree” to “strongly agree”). One item has the option of a 0 rating (unable to ascertain) because of the difficult nature of the question. A total score for the first fifteen items is computed to assess the level of engagement in treatment. Total scores can range from 0 to 60, with higher scores reflecting more engagement in treatment.

Paulhus Deception Scale (PDS)

The Paulhus Deception Scale, developed by Paulhus (1998), was formerly known as the Balanced Inventory of Desirable Responding. It is a 40-item, self-report instrument that measures the tendency to give responses viewed as socially desirable. The PDS is useful in identifying individuals who distort their responses and in evaluating the honesty of their responses, especially when administered concurrently with other instruments. The PDS takes 5 to 7 minutes to complete and can be employed within both clinical and nonclinical settings (Paulhus, 2000).

The items on the PDS measure two principal forms of socially desirable responding: Self-Deceptive Enhancement (SDE) and Impression Management (IM). The SDE Scale provides information on the tendency to provide agreeable self-perceptions that are due to an overly confident, yet inaccurate, self-view. The IM Scale renders information on the tendency to purposely respond to items in an attempt to make themselves appear amiable to the evaluator (MHS, 2000).

The IM scale is of the most interest in this study. Internal reliability has a Cronbach's alpha coefficient of .75 for the SDE scale, .84 for the IM scale, and .85 for the total scale. In terms of convergent validity, the IM scale correlates highly with a cluster of measures traditionally known as lie scales and role-playing measures, however, no values were recorded in the manual (MHS, 2000).

Wide Range Achievement Test (WRAT-3)

The WRAT-3 is a brief, individually administered achievement test that was developed by Jastik and Wilkinson (1984) and was used to determine the reading level of all individuals who had consented to participation in the study. The WRAT-3 contains

two versions of three subtests: Reading, Spelling, and Arithmetic, however, only the Reading subtest was administered. The Reading subtest measured the ability to recognize and name letters and pronounce words. Studies on item bias were performed on earlier versions of the WRAT. There was no difference on item difficulty between white and non-white groups for reading. The median test coefficient alphas range from .85 to .95 over the nine WRAT-3 tests. For the Reading subtest, there is a median correlation of .93 between the two versions.

Record Form

The Record form (see Appendix D), developed for the present study, was used to gather sensitive information from the participants' files regarding characteristic of victims, polygraphs administered and failed, and number of warnings for dismissal.

Demographics Data Sheet

Demographic data (see Appendix E) were collected from each participant at the beginning of the testing session. The demographic data sheet was designed to collect a variety of data including age, ethnicity, education, marital status, religious orientation, occupation, and important aspects related to treatment.

Procedure

Participants were recruited from outpatient therapy groups at both the Professional Associates Counseling and Consultation Center and the Psychotherapy Services and Yokefellows Center in Fort Worth, Texas. Participants were recruited during their regularly scheduled group treatment session. Participants were informed that the ultimate goal of the study was to better understand and provide more effective treatment for individuals who commit sexual offenses against children.

In recruiting participants, an announcement was made regarding the nature of the study (with a discussion of length of time required to fill out the questionnaires, voluntary participation, and the right to withdraw at any time without consequence). Individuals were told that their choice to participate would not affect their treatment. However, individuals were also informed that one benefit to participating is that there would be additional data available to their treating clinician. Data from the first testing session (self-ratings) was reported and given to their treatment provider to become part of their clinical file, which could then be used to assist in their treatment. Participants were also told that they would receive a copy of these results. However, research records from the second testing session (typical child molester ratings) remained confidential and anonymous and were not reported back to the treatment center or to the participants.

Informed consent was obtained from each participant prior to the administration of the measures. During the first testing session, written consent forms briefly explaining the participants' roles and details involved in the study were given to each group member. The consent form was read aloud and questions concerning the project were answered. Group members who agreed to participate in the study signed the consent form. A master list, which was kept in a secure area, matched names of participants to assigned research numbers. These numbers were on all data forms. The master list linking participants' names with their identification number was destroyed after the data collection was complete.

After consent forms were signed, reading ability, determined by the Wide Range Achievement Test, was assessed on an individual basis. Individuals who had a difficult

time reading at the level required by the instruments in the study were exempt from further testing.

After reading ability was established, all eligible participants were asked to complete a demographics form (see Appendix E), the NEO-PI-R, Form S, and the Paulhus Deception Scale. On the second day of testing, participants were instructed to answer questions on the NEO-PI-R, Form R, based on their perceptions of a typical child molester. At least two weeks were scheduled between the two test administrations so that individuals would be less likely to remember their specific responses. For instance, a two-week interval would make it less likely for the participants to be aware of responding in a deliberately consistent or inconsistent way. Sixty-four individuals were re-tested between two and four weeks after their initial testing session and three individuals were re-tested between four to five-and-a-half weeks after their initial testing session.

During both testing sessions, the questionnaires were administered in a group format during or following the participants' group treatment sessions. Individual sessions were also scheduled for those who were unable to participate at the time of testing.

The therapist who is responsible for treating the participating offenders was asked to fill out the Evaluation of Offender (EVAL-O) questionnaire for each participant (see Appendix B). Therapists were instructed, after participants' completed their second day of testing, to complete the EVAL-O within a two week time period. However, some participants were not rated on this measure until 3 months after they completed their questionnaires. Last, case files were used to gather additional information on the client (see Appendix D).

CHAPTER 3

RESULTS

Descriptive Statistics

In terms of demographic data, all participants were male and ranged in age from 18 to 76, ($M = 43.14$; $SD = 11.20$). The majority of the sample (76.1%) was Caucasian. Over half of the participants (68.6%) earned either a GED or high school diploma or had some college education. All participants listed having a recent occupation, except one, who claimed to be a retired US Marine. The average amount of annual income earned was \$30,382 dollars. Approximately half of the participants (46.3%) were married or living as married and the majority of individuals (88.1%) rated themselves as having a heterosexual orientation. Among the sample, there were a wide variety of religious orientations. Refer to Tables 1 and 2 in Appendix A for a complete description of demographic data and other status variables.

When exploring the data from both forms of the NEO-PI-R, 9 individuals had a total of 12 scores on one of the five factors that were either 2.5 standard deviations above or below the mean. Because these scores were considered to be outliers, they were trimmed by replacing the outlier with the next highest or lowest score that was within 2.5

standard deviations of the mean. Thus, the results presented in this section are based on the trimmed scores.

In addition, when the absolute difference scores from how sexual offenders viewed themselves versus a typical child molester were examined, it was determined that distributions of Extraversion and Openness to Experience were positively skewed. Therefore, the absolute difference scores from these two factors were transformed by logarythmic transformations in order to meet the assumptions for normality. Therefore, all results in this section which describe how sexual offenders view themselves in relation to a typical sexual offender on Extraversion and Openness to Experience are based on logarythmic transformed scores.

On the NEO-PI-R, form S, participants rated themselves as high on the Neuroticism subscale ($\underline{M} = 94.43$; $\underline{SD} = 19.90$), average on the Extraversion subscale ($\underline{M} = 105.33$; $\underline{SD} = 17.20$), average on the Openness subscale ($\underline{M} = 109.03$; $\underline{SD} = 16.23$), average on the Agreeableness subscale ($\underline{M} = 112.85$; $\underline{SD} = 16.24$), and low on the Conscientiousness subscale ($\underline{M} = 112.43$; $\underline{SD} = 19.65$).

Refer to Tables 3, 4, and 5 in Appendix A for inter-correlations between the NEO-PI-R self-ratings and ratings of the typical child molester.

Hypothesis Testing

First, it was hypothesized that, on the NEO-PI-R, sex offenders would, on average, rate a typical child molester as high in Neuroticism, low in Extraversion, low in Openness to Experience, low in Agreeableness, and low in Conscientiousness. In order to test this hypothesis, means and standard deviations were calculated on all the factors on the NEO-PI-R, form R. Comparisons with non-clinical test norms demonstrated that

participants rated a typical child molester as very high on Neuroticism ($M = 120.39$; $SD = 17.02$), average on Extraversion ($M = 100.37$; $SD = 16.36$), average on Openness to Experience ($M = 103.94$; $SD = 13.60$), low on Agreeableness ($M = 86.34$; $SD = 18.43$), and low on Conscientiousness ($M = 88.22$; $SD = 19.93$). Because Openness to Experience and Extraversion fell in the average range, this hypothesis was only partially supported.

To evaluate whether these scores were significantly high or low in comparison to a normal population of male individuals, a one sample t-test was computed between each of the mean scores and the average scores from the standardization sample of men who completed the NEO-PI-R. Results from these analysis indicated that sexual offenders rated, on average, a typical sexual offender as high in Neuroticism ($t(66) = 21.73$, $p < .001$), low in Extraversion ($t(66) = 4.07$, $p < .001$), low in Openness to Experience ($t(66) = 3.71$, $p < .01$), low in Agreeableness ($t(66) = 15.00$, $p < .001$), and low in Conscientiousness ($t(66) = 14.53$, $p < .001$). Thus, even though a typical child molester was rated as being in the average range on Extraversion and Openness to Experience, the scores on these two factors were rated as being significantly lower than the average scores of a population of normal individuals. All components of this hypothesis were supported when data were analyzed this way.

Finally, to evaluate whether these scales were significantly high or low in comparison to each other, dependent samples t-tests were computed between all five factors. Results from these analyses indicated that Neuroticism was rated significantly higher than Extraversion ($t(66) = 6.96$, $p < .001$), Openness to Experience ($t(66) = 7.32$, $p < .001$), Agreeableness ($t(66) = 8.73$, $p < .001$), and Conscientiousness ($t(66) = 8.05$, $p < .001$). Extraversion was rated significantly higher than Agreeableness ($t(66) = 4.99$, $p <$

.001) and Conscientiousness ($t(66) = 4.12, p < .001$) and significantly lower than Neuroticism ($t(66) = 6.96, p < .001$). The difference between Extraversion and Openness to Experience was non-significant ($t(66) = 1.77, p = .082$). Openness to Experience was rated significantly higher than Agreeableness ($t(66) = 6.40, p < .001$) and Conscientiousness ($t(66) = 5.05, p < .001$), but significantly lower than Neuroticism ($t(66) = 7.32, p < .001$). Finally, Agreeableness was rated significantly lower than Neuroticism ($t(66) = 8.73, p < .001$), Extraversion ($t(66) = 4.99, p < .001$), and Openness to Experience ($t(66) = 6.40, p < .001$), but did not significantly differ from Conscientiousness ($t(66) = .825, p = .413$). Results for all three analyses in reference to hypothesis 1 are summarized in Table 6 in Appendix A.

Second, it was hypothesized that, on the NEO-PI-R, sexual offenders who viewed themselves as being similar to the typical sex offender would be rated as more engaged in treatment, as noted on the EVAL-O by their treatment providers. As a precursor to this hypothesis, a within subjects Multivariate Analysis of Variance (MANOVA) was performed to test significant mean differences between the NEO-PI-R administrations (Forms S and R). Differences between Neuroticism (N), Extraversion (E), Openness (O), Agreeableness (A), and Conscientiousness (C) were explored. Overall multivariate results (Wilks' Lambda = .647; $F = 36.07, p < .001$) were significant. Paired samples t-tests were followed up to test for significant differences between each of the five factors. Results were significant for Neuroticism ($t(66) = 9.15, p < .001$), Extraversion ($t(66) = 2.09, p < .05$), Openness to Experience ($t(66) = 2.94, p < .01$), Agreeableness ($t(66) = 10.09, p < .001$), and Conscientiousness ($t(66) = 8.20, p < .001$). These results indicate that the two forms (S and R), which varied by the instructions, produced different results for all five scales.

Participants in this study rated themselves, when compared to a typical child molester, significantly lower in Neuroticism (Self \underline{M} = 94.43; \underline{SD} = 19.89; Typical \underline{M} = 120.39; \underline{SD} = 17.02) and significantly higher in Extraversion (Self \underline{M} = 105.33; \underline{SD} = 17.20; Typical \underline{M} = 100.37; \underline{SD} = 16.36), Openness to Experience (Self \underline{M} = 109.03; \underline{SD} = 16.23; Typical \underline{M} = 103.94; \underline{SD} = 13.60), Agreeableness (Self \underline{M} = 112.85; \underline{SD} = 16.24; Typical \underline{M} = 86.34; \underline{SD} = 18.43), and Conscientiousness (Self \underline{M} = 112.43; \underline{SD} = 19.65; Typical \underline{M} = 88.22; \underline{SD} = 19.93). Study participants rated themselves as most different from a typical child molester on Neuroticism, Agreeableness, and Conscientiousness.

Regressions were then used to determine how the match between self and other ratings on the NEO-PI-R forms S and R (or level of self-identification) related to treatment engagement. The match between self and other ratings was obtained by taking the absolute difference between the two scores. Overall treatment engagement was quantified by the sum of the first fifteen items on the EVAL-O. Regressions were computed for all five factors entered as one block. Inter-correlations of the absolute differences scores for all five factors are shown in Table 7 in Appendix A. Inter-correlations and regression results for all five factors in relation to treatment engagement are shown in Table 8 in Appendix A. The overall regression equation as well as individual factors in the regression equation were all non-significant.

Third, it was hypothesized that being in treatment for an extended period of time and having a lengthy sexual offense history would be associated with offenders viewing themselves as being more similar to a typical sexual offender. To test these hypotheses, two separate sets of regression analyses were used to determine how the match between self and other ratings on the NEO-PI-R, forms S and R, (or level of self-identification)

related to time in treatment and number of victims. Length in treatment and number of victims were employed separately as criterion variables. Regressions were computed for all five factors entered as one block. For time in treatment, the overall regression equation as well as individual factors in the regression were all non-significant. For number of children abused, the overall equation was significant. How an offender viewed himself in relation to a typical child molester on Neuroticism, Extraversion, and Agreeableness was significantly related to the number of children he abused. Specifically, there was a positive correlation between the number of children abused and the offenders' views of himself as similar to a typical sex offender on both Neuroticism and Agreeableness, whereas a negative correlation existed between number of children abused and degree of match on Extraversion. Agreeableness and Conscientiousness were the only two factors that uniquely and robustly predicted number of children abused, with non-significant trends being present for Neuroticism and Extraversion. The effect size was small to moderate in that they accounted for 30% of the variance. Inter-correlations and regression results for all five factors in relation to time in treatment and number of victims are shown in Tables 9 and 10 in Appendix A respectively.

Fourth, it was hypothesized that individuals who viewed themselves in a positive light and rated themselves as having desirable personality characteristics on the NEO-PI-R (e.g., low Neuroticism, high Agreeableness, high Openness to Experience, high Extraversion, and high Conscientiousness) were likely to have higher treatment engagement. To test this hypothesis, a series of one-tailed Pearson Product Moment Correlations were computed between the self-ratings on the five scales of the NEO-PI-R and overall treatment success, as quantified by the sum of the items on the EVAL-O. As

this was a directional hypothesis, the test for significance of the correlations were one-tailed. The relation between Neuroticism and treatment engagement ($r = -.20, p = .05$) showed a marginally significant trend. The relation between Extraversion and treatment engagement ($r = .01, p = .48$) was non-significant. The relation between Openness to Experience and treatment engagement ($r = .04, p = .36$) was non-significant. The relation between Agreeableness and treatment engagement ($r = .12, p = .16$) was non-significant. The relation between Conscientiousness and treatment engagement ($r = .19, p = .07$) showed a marginally significant trend.

As a follow up, specific questions from the EVAL-O that related to treatment engagement were examined. A significant negative correlation was found between Extraversion and good attendance ($r = -.21, p < .05$), punctuality to group ($r = -.30, p < .01$), and appropriate excuses for absences and/or tardiness ($r = -.29, p < .01$). A significant positive correlation was found between Extraversion and active participation in group ($r = .20, p < .05$). A significant negative correlation was found between Neuroticism and taking responsibility for sexual offense ($r = -.21, p < .05$) and expressing remorse for the pain/suffering caused to victims ($r = -.21, p < .05$). Last, a significant positive correlation was found between Conscientiousness and lack of minimization for sexual offenses ($r = .21, p < .05$). See Table 11 in Appendix A for correlations of the five factors, overall treatment engagement, and items pertaining to treatment engagement that demonstrated significant results.

Fifth, it was hypothesized that individuals who portrayed themselves in a positive light by endorsing socially desirable personality traits on the Paulhus Deception Scale would be rated as more engaged in treatment. In order to test this research hypothesis,

Pearson Product Moment Correlations were computed between the impression management scale on the Paulhus Deception Scale and overall treatment success, as quantified by the sum of the items on the EVAL-O. As this was a directional hypothesis, the tests for significance of the correlations were one-tailed. Results were non-significant ($r = -.16$, $p = .10$) between and impression management and treatment engagement. As a follow up, specific questions from the EVAL-O that related to treatment engagement were examined. A significant negative correlation was found between impression management and positive behavior in group ($r = -.21$, $p < .05$), lack of minimization ($r = -.23$, $p < .05$), responsibility for sexual offenses ($r = -.21$, $p < .05$), admitting a need for treatment ($r = -.25$, $p < .05$), motivation for treatment/recovery ($r = -.26$, $p < .05$), and understanding of concepts taught in group ($r = -.23$, $p < .05$).

Supplemental Analyses

Other analyses were explored to test questions derived from the existing literature and from clinical experience. A supplemental analysis explored whether the expression of genuine remorse for a victim was related to treatment engagement. This possibility was tested via a two-tailed Pearson Product Moment Correlation. Results demonstrated a positive relation ($r = .77$, $p < .001$). Another supplemental analysis explored whether having a negative reaction to an offender was related to treatment engagement. Results showed a negative relation ($r = -.66$, $p < .001$).

The relation between length of time in treatment and treatment engagement was evaluated. Results showed a positive relation ($r = .30$, $p < .01$).

An exploratory correlation matrix was calculated using all variables from treatment engagement, clinicians' ratings of the intelligence level of offenders, as well as

having a negative reaction to the offenders. Results for these analyses are shown in Table 12 in Appendix A.

Two exploratory correlation matrices were calculated using participants with high versus low Paulhus Deception Scale scores and the absolute difference scores of all five NEO-PI-R factors, time in treatment, offense history (i.e., number of victims abused), and treatment engagement. For those with low PDS scores, results demonstrated a positive relation between Neuroticism and number of children abused ($r = .45, p < .01$) and Agreeableness and number of children abused ($r = .45, p < .01$). There was also a positive relation between time in treatment and treatment engagement ($r = .49, p < .01$) for the participants who scored in the low range on the PDS. These relationships were non-significant for individuals with high PDS scores.

Supplemental analyses were also conducted using the overall treatment engagement score and the six facet scores on both Neuroticism (i.e., Anxiety, Angry Hostility, Depression, Self-Consciousness, Impulsiveness, and Vulnerability) and Conscientiousness (i.e., Competence, Order, Dutifulness, Achievement Striving, Self-Discipline, and Deliberation). Results demonstrated a negative relation between treatment engagement and Vulnerability ($r = -.25, p < .05$) and a positive relation between treatment engagement and Competence ($r = .26, p < .05$).

CHAPTER 4

DISCUSSION

Perceptions of a Typical Child Molester

The first hypothesis proposed that, on the NEO-PI-R, sex offenders would, on average, rate a typical child molester as high in Neuroticism, low in Extraversion, low in Openness to Experience, low in Agreeableness, and low in Conscientiousness. Because sexual offenders are repeatedly portrayed in a negative light by the media and are generally looked down upon by individuals in our society, it was expected that sex offenders would, on average, rate a typical child molester as possessing less desirable personality traits. This hypothesis was generally supported by the results. When data were examined in terms of their means and in relation to the standard categorizations of the NEO-PI-R, three of the scales were consistent with the hypothesis. Sexual offenders viewed a typical child molester as high in Neuroticism, low in Agreeableness, and low in Conscientiousness, as expected. However, typical child molesters were rated as being average on Extraversion and Openness to Experience versus low, as predicted. A second analysis statistically compared the means of the present sample to the means of the standardization sample. From this perspective, all aspects of hypothesis were supported by the research results. Thus, a typical sexual offender was, on average, rated as high in Neuroticism and low in Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. Analysis of the variation of scores within the current sample also

yielded results generally consistent with the hypothesis. These results indicate, overall, that child molesters continue to be evaluated in a negative light, even by those who have been committed of a child sexual offense. Typical child molesters are seen as neurotic and low in levels of Agreeableness and Conscientiousness. To a lesser degree, they also were seen as low in Extraversion and Openness to Experience.

In general, child molesters' negative ratings of a typical offender may be a result of overwhelming condemnation by others or a longstanding view due to societal scrutiny (Horley et al., 1997). For example, Weekes and colleagues (1995) found that correctional officers perceived sex offenders to be more dangerous, harmful, violent, tense, bad, unpredictable, mysterious, unchangeable, aggressive, weak, irrational, and afraid compared with non-sex offenders. Sex offenders against children were judged to be significantly more immoral and mentally ill than sex offenders against women, who were judged to be more immoral and mentally ill than non-sex offenders. According to the authors, the finding that sex offenders were perceived to be more mentally ill in comparison with non-sex offenders supported the commonly held belief that the behavior of sex offenders is "sick" or that a person must be "crazy," deranged, or mentally ill to commit a sex offense. It appears that the child molesters in this study maintained these perceptions.

The moderate findings on Extraversion and Openness bear additional consideration. A prevalent belief about men who sexually molest children is that they are passive, socially inadequate people who turn to children as a result of rejection by adults, usually women (Levin & Stava, 1987). Wilson and Cox (1983) used the Eysenck Personality Questionnaire (EPQ) to study pedophiles and found that pedophiles are

introverted and lack social skills. A number of researchers have consistently observed that sexual offenders are socially isolated, lonely individuals who appear to have few intimate relationships (Ward, McCormick, et al., 1997). They also tend to be private individuals, thought of as having low social skills, who live somewhat solitary lifestyles (Pressor & Gunnison, 1999). However, many child molesters also possess the charismatic skills to attract children and gain trust in adults. Thus, they do have some outgoing characteristics. Therefore, it is possible that a typical child molester was rated as closer to average on Extraversion because molesters may be thought of as possessing both extraverted and introverted characteristics.

In terms of Openness to Experience, it is assumed that a typical child molester must be open to some new experiences in order to seek out novel victims; however, he may also be seen as set in his ways and resistant to change. Thus, it is understandable why a typical molester may have been rated as closer to average on this factor.

Self-Perceptions

Because of the great condemnation in the community at large directed against sexual abusers of children, some investigators argue that offenders will internalize a negative view of themselves (Horley et. al., 1997). However, based on the results of this study, this did not seem to occur. In fact, sexual offenders saw themselves, overall, as more positive on all of these factors compared to their view of the typical sex offender. Participants in this study rated themselves, when compared to a typical child molester, significantly lower in Neuroticism and higher in Extraversion, Openness to Experience, Agreeableness, and Conscientiousness. Overall, these results imply that child molesters who are in outpatient treatment for a child sexual offense view themselves in a more

positive light than their view of a typical child molester. There are a variety of reasons to support why sexual offenders did not internalize a negative self-perception.

Rejection of a Negative Self-Perception

External Attributions

One possible explanation results from attribution theory. Attribution theory is concerned with the process whereby individuals explain their own behavior and the behavior of others (Fosterling, 1988). Heider (1958) is considered to be the founder of attribution theory. He identified that people either make internal attributions, in which causal explanations for actions are located within an individual, or external attributions, which locate causal explanations for behavior in outside social and environmental factors. According to Blumenthal and colleagues (1999), attributions are relevant to the way in which offenders attribute blame for criminal acts. Social cognitive research into child molesters' attributional processes has found that molesters tend to have difficulty accounting for their sexually deviant behavior. Many ascribe their offenses to external factors. For example, there is a tendency for offenders to blame their behavior on societal factors or the victims' provocation (Storms, 1973). This helps them to appear more normal and also has the purpose of reducing guilt and anxiety and maintaining self-esteem.

State-Based Motives

Similarly, Nisbett, Caputo, Legant, & Maracek (1973) found that when participants were asked to describe themselves and others by designating a trait (e.g., talkative), a contrasting trait (e.g., quiet), or a phrase that depends on the situation, respondents selected the situation option more frequently to describe themselves than to

describe others. Nisbett et al. (1973) took these findings as evidence that we are more reluctant to offer trait-based explanations for our own behavior than for that of others. More specifically, these authors argued that because we have greater knowledge of the situational promptings of our own behavior than of the behavior of others, as well as greater awareness of the situation-to-situation variability of our own behavior, we are less inclined to see our actions as driven by global personality dispositions.

Differentiation

Along the same lines, Mirels and colleagues (1998) asked 134 undergraduates to complete 4 questionnaires using the Personality Research Form which asked them to describe themselves and 4 others (e.g., a person they like and know well, a person they like and do not know well, a person they dislike and know well, and a person they dislike and do not know well). In this study, participants showed greater differentiation in descriptions of themselves than of others. The more differentiation there is, the less that individual is seen as showing the kind of consistency among behavioral predispositions implied by global traits. The less differentiated an individual is seen, the more stereotypically trait-like description he/she is given. The authors concluded that self-conceptions of individuals in responses to their own personality test items reveal greater differentiation (less trait-like consistency) than conceptions of others (Mirels, Stevens, Greblo, & Yurek, 1998). The findings in this study support the idea that offenders were describing themselves in a more differentiated way than they describe a typical child molester.

Avoiding Stigma

Another reason why sexual offenders may fail to see themselves as negatively as a typical molester is because they are trying to avoid self-stigma to maintain their self-esteem. Self-stigma occurs when individuals assimilate social stereotypes about themselves. Self-stigma results in a loss of self-esteem, diminished self-efficacy, and a hesitancy to participate in society at large. Individuals then question their ability to cope effectively with daily challenges they face (Holmes & River, 1998). Stigma has a significant impact on an individual's view of himself or herself and is claimed to be a primary obstacle to recovery for mental illness (Holmes & River, 1998). If offenders take on the impression that they are mentally ill, they may have less hope in their ability to recover. Thus, one of the reasons they are not taking on this negative view may be to maintain their self-esteem and believe in their ability to benefit from treatment.

Involvement in Treatment

It is also possible that because these individuals are in outpatient treatment (as opposed to prison) for the offense they committed, they may believe that they are not “as bad” as child molesters who are not granted permission to reside in the community. In support of this conjecture, Bahn and Davis (1991) investigated the social-psychological effects of 43 probationers, most charged with felonies, property, and drug crimes. The majority had been on probation from 1 to 3 years. The mean number of prior arrests was 1.3. On a self-concept inventory, the majority of probationers stated they preferred probation to jail or prison and felt good about themselves. The majority did not see themselves as criminals and did not see themselves as bad persons. Most rationalized their criminal activity and gave excuses and justifications for their crimes.

Offense History

In addition, the demographic statistics show that sixty percent of the sample reported to have abused only one child. An additional thirty percent abused between two and six children. Therefore, the majority of these sexual offenders may believe that the number of children they abused was relatively low compared to a typical sexual offender. Perhaps being in treatment affects the way that sexual offenders view themselves compared to a typical child molester. For instance, they may not consider themselves as typical sexual offenders based on the fact they are receiving treatment for their offense(s). Data were gathered to test these latter projections; however, there was no evidence to substantiate them. Future research should continue to examine some of these possibilities especially with larger sample sizes.

Social Desirability

Because the scores on the NEO-PI-R (self-ratings) were to be reported to their treatment providers, it is also important to consider that the overall positive expression might be an effect of self-presentation, indicating molesters' desire to look good to their treatment providers. Overholser and Beck (1986) found child molesters to be significantly higher on the fear of negative evaluations scale compared to rapists, non-sex-offender prisoners and volunteers. Because offenders against children have fears of being negatively evaluated by others, they may have been providing a positive self-presentation. However, this is unlikely considering the offenders endorsed being honest on the validity checks. In addition, their scores were in the average range. If scores were exceedingly positive, this may have been a concern; however, there was no indication that this was the case.

Treatment Engagement

Second, it was hypothesized that, on the NEO-PI-R, sexual offenders who viewed themselves as being similar to the typical sex offender would be rated as more engaged in treatment, as noted on the EVAL-O by their treatment providers. It was thought that individuals who saw themselves as being similar to their view of a typical sexual offender would be more likely to accept their need for help. Consequently, they would be less resistant to treatment and would be more engaged in treatment. This hypothesis was completely unsupported. How a sexual offender views himself in relation to a typical sexual offender in regard to personality traits was shown to have no relation to his level of engagement in treatment. Although a sexual offender may view himself as very different or very similar from his view of a typical child molester, treatment engagement appears independent of this view. Treatment engagement, therefore, appears to be influenced by other variables aside from self-perceptions on personality factors. Knowing about variables that contribute to treatment progress may assist with knowing how to affect one's level of engagement in treatment.

Variables related to Treatment

Pribyl (1998) used an interview to examine the perceptions of 13 child sex offenders participating in outpatient sex offender treatment regarding their views on factors directly related to treatment, and separate from treatment, that had contributed to their treatment progress and that had helped to keep them from reoffending. He also explored factors that had interfered with treatment progress. Pribyl found a variety of themes that reduced the reoffending potential. Increased awareness of the connection between thoughts, feelings, and behaviors, the use of specific interventions, telling the

truth, the fear of consequences, and victim empathy, emerged as significant. The two most significant factors identified as interfering with recovery were perceived negative therapeutic/therapist qualities and significant others who did not work collaboratively with the offender in his recovery. Pribyl acknowledged that this topic area was widely unexplored and recommended that additional studies continue to examine offenders' perceptions of treatment and related factors. While examining some of these characteristics in relation to treatment engagement in this study, there was support for some of Pribyl's findings. In this study, expressing genuine remorse for the pain/suffering caused to his victim(s) was considered to be equivalent to victim empathy. This variable was examined with treatment engagement. A highly significant positive relationship was found between remorse and treatment engagement. Treatment engagement was also examined with the therapist's positive/negative reaction to the client. The more negative the therapist's reaction, the less the client was engaged in treatment. Although this does not directly test Pribyl's assertion, these findings lend support for the interaction between therapist qualities and clients' engagement in treatment.

Beech and Fordham (1997) administered a measure of group atmosphere to the group leaders and group members of 12 sexual offender treatment groups and compared it to results from a measure that identified short-term treatment effectiveness, which encompassed scales measuring level of cognitive distortions, level of denial, fixations on children, admission of offense behaviors, and level of social inadequacy. Results suggested that the atmosphere of the group had an important influence on treatment change. Scores on group atmosphere predicted positive changes during the course of treatment in acceptance of responsibility, attitudes and beliefs about sex with children,

and social adequacy. A successful group was highly cohesive, well organized and led, encouraged the open expression of feelings, produced a sense of group responsibility, and instilled a sense of hope in its members. A helpful and supportive group leadership style was found to be important in creating an atmosphere in which effective therapy could take place. Contrary to the above, Sadoff, Roether, and Peters (1971) found that sex offenders who reported that group psychotherapy was helpful when asked at the end of treatment were actually more likely to be rearrested than sex offenders who complained about their group involvement. Although variables related to group atmosphere were not collected in the present study, such variables might account for much of the variance in treatment engagement and represent an important area of future investigation.

Criassati and McClurg (1997) assessed over 80 convicted perpetrators of child sexual abuse in London over a 2-year treatment period and followed them up 1-2 years later. Two variables were closely associated with poor treatment compliance: a history of sexual and/or violent offending and a history of childhood sexual victimization. Thus, noncompliance or failure in treatment appears to be related to static rather than dynamic variables. Although the authors state that certain variables taken in conjunction, including a history of child sexual abuse, a previous history of sexual or violent offending, high levels of cognitive distortions, extrafamilial offending, and perhaps long term heavy substance misuse may indicate a poor prognosis in terms of treatment compliance, it is not yet clear whether noncompliance is an accurate predictor of sexual reoffending. In the present study, history of childhood sexual victimization was not assessed; however, an extensive history of offending did not have any significant relation to treatment compliance.

Further, Seto and Barbaree (1999) examined information on treatment behavior, retrospectively, for 283 sex offenders and its relationship with outcome (e.g., parole failure, general recidivism, sexual recidivism, etc.). The results of their study did not support the notion that good treatment behavior (defined in terms of positive and appropriate behavior in group sessions, good homework assignments, and positive ratings of motivation and overall change) was associated with better outcomes. In fact, men who scored higher on the PCL-R and who behaved well in treatment were more likely to commit a new offense of some kind, and much more likely to commit a new serious offense. On the other hand, Harris, Rice, and Cormier (1991) found a relation between treatment behavior and recidivism in a sample of forensic patients that included sex offenders. Offenders who committed a new violent offense were more likely to behave poorly while in treatment (as indicated by the number of entries about noncompliant or aggressive behavior in their clinical records, the number of times they were disciplined, and the amount of time that passed before they were recommended by staff for discharge from the program). Thus, it may be that only over longer periods of time will we be able to assess whether ratings of compliance/noncompliance are reliable and valid predictors of reoffending (Craissati & McClurg, 1997).

Offense History, Time in Treatment, and Self-Perceptions

Third, it was hypothesized that being in treatment for an extended period of time and having a lengthy sexual offense history would be associated with offenders viewing themselves as being more similar to a typical sexual offender. Initially, it was thought that individuals who had been in treatment for a long time would view themselves as being similar to a typical child molester because of expectations from their treatment

providers. However, length of time in treatment was not related to how a sexual offender viewed himself in relation to a typical child molester. It may be that sexual offenders who are in treatment for a longer period of time are in treatment so long because they have difficulty accepting or taking responsibility for what they did. Because of their difficulty, they are not likely to identify themselves as a typical child molester. Oftentimes, when child abusers are first caught or convicted, they are in denial and frequently minimize their behavior (Briggs & Hawkins, 1996; Maletzky, 1991; Marshall, 1994; Murphy, 1990). Therefore, some individuals who are new to treatment and who have had less time in treatment, may also be unlikely to see themselves as being similar to a typical child molester. Given these views (i.e., individuals new to treatment are unable to identify themselves as a typical child molester because they generally have not taken appropriate responsibility for their actions, and individuals in treatment a long time are likely to remain in treatment because they are unable to identify themselves as a typical child molester), it was reconsidered that the sexual offenders with an average amount of time spent in treatment would actually view themselves as being most similar to a typical child molester. However, when examining each of the five factors according to length of time in treatment, there were no significant differences in regard to offenders' views about themselves in relation to a typical child molester. During all phases of treatment, offenders saw the biggest differences between themselves and a typical offender on Neuroticism, Agreeableness, and Conscientiousness, whereas they saw themselves more similar to a typical child molester on Extraversion and Openness to Experience. Intuitively, it seems that individual items measuring the latter two factors would be less

threatening and would instigate less reactivity in offenders' responses. Thus, being more similar to a typical offender in these domains seems reasonable.

Time in Treatment

In addition, results in this study displayed a significant and positive relation between time in treatment and engagement in treatment. Thus, the longer time spent in treatment, the more engaged the offender was rated. However, results demonstrated that when offenders are being deceptive or trying to present themselves positively, therapists do not believe they are more engaged in treatment, even when they have a longer history of treatment. Thus, only long-term attenders who are able to be honest with themselves and their treatment providers may be truly benefiting from prolonged treatment. Clinicians, therefore, should continue to institute lengthy treatment programs for these offenders. Unless offenders' are able to lower their level of desirability and level of deception, the length of treatment will not matter.

Offense History

The third hypothesis also predicted that the number of victims an offender perpetrated against would be associated with offenders viewing themselves as being more similar to a typical sexual offender. The rationale for this hypothesis was that perpetrating against a considerable number of children would make it difficult for the offender to deny that he is similar to a typical child molester. This hypothesis was not fully supported. In fact, one result directly contradicted it. On Agreeableness and Neuroticism, the more dissimilar individuals saw themselves compared to a typical child molester, the more child victims they perpetrated against. Distinguishing between individuals who were being non-deceptive and deceptive showed that only non-deceptive offenders exhibited

this relation. Thus, deception goes beyond just presenting oneself favorably, but extends to how molesters view their personality and how many children they admit to abusing. When sex offenders saw themselves more similar to their view of a typical child molester in terms of Conscientiousness and Extraversion, the more children they abused. The strongest unique combination was found with Agreeableness and Conscientiousness. Thus, when a sex offender sees himself, in comparison to a typical sex offender, as low in Conscientiousness (e.g., unreliable, lax, prefers not to be accountable for his actions, etc.), and highly Agreeable (e.g., trustworthy, sympathetic, personable, goes out of way to please others, easy to spend time with) (Costa & McCrae, 1992a; Muten, 1991; Piedmont & Ciarrochi, 1999), he is likely to have perpetrated against more victims.

Investigating various relations with a history of sexual offending remains an important area to study because men who have a longer history of sexual offending are stated to be at greater risk (e.g., more than twice as likely) to commit future sexual offenses (Gordon & Porporino, 1990). Prentky and colleagues (1997) stated that a longer criminal history and a history of impulsive antisocial behavior is a well-documented risk factor associated with child molesters. They note that three variables predicted sexual recidivism: degree of sexual preoccupation with children, paraphilias, and number of prior sexual offenses.

In his research, Maletzky (1991) also found that certain factors were strongly associated with treatment failure (which included factors relating to treatment engagement, deviant arousal, recidivism, etc.). One of these factors was number of victims. If the offender had offended against several victims, the chance of failing treatment was eight times higher than if he had but a single victim. In sum, individuals

who consider themselves as trustworthy, sympathetic, cooperative, compliant and personable (Costa & McCrae, 1992a; Muten, 1991) but are not very reliable or goal-oriented, are less mindful of their actions, and prefer not to be held accountable for actions (Costa & McCrae, 1992a; Muten, 1991; Piedmont & Ciarrocchi, 1999) may not only predict a more extensive history of offending, but may actually be considered to be more at-risk for committing future sexual offenses.

Given the above findings, it is also believed that recidivism should be relatively low among those who have committed fewer offenses (Furby et al., 1989). However, individuals with less extensive histories are also stated to be the most minimizing and denying of the sexual offender types, insisting that it only happened once (Gordon & Porporino, 1990). This was not supported by our research findings. When investigating the relation between the number of children abused and factors that relate to engagement in treatment, having a less extensive offense history was not associated with more minimization, taking less responsibility for offenses, or being less motivated for treatment. If this prediction should hold true in the future, it will be important to target these individuals in order to increase their engagement in treatment, help them take responsibility for offenses, and decrease their minimization. In the meantime, it is important to investigate other factors, aside from self-perception, that are associated with perpetrating against large numbers of children. These factors can be a focus of clinical attention when trying to intervene and/or prevent sexual recidivism.

Personality Factors and Overall Treatment Engagement

Fourth, it was hypothesized that individuals who viewed themselves in a positive light and rated themselves as having desirable personality characteristics on the NEO-PI-

R (e.g., low Neuroticism, high Agreeableness, high Openness to Experience, high Extraversion, and high Conscientiousness) were likely to be more engaged in treatment. It was argued that individuals who viewed themselves in a positive light by rating themselves as having desirable personality characteristics on the NEO-PI-R (e.g., low Neuroticism, high Agreeableness, high Openness to Experience, high Extraversion, and high Conscientiousness) would likely try to behave in accordance with these views in relation to the treatment providers. Thus, treatment providers would rate these individuals positively on variables related to treatment engagement. Results demonstrated that only two factors, Neuroticism and Conscientiousness, were related to more engagement in treatment. The less neurotic sexual offenders rated themselves, the more engaged in treatment they were rated having by their treatment providers. Similarly, the more conscientious sexual offenders rated themselves, the more they were engaged in treatment. When looking more specifically at these broad domains, those who were less vulnerable (i.e., emotionally stable and maintaining good coping skills) and more competent (i.e., possessing intelligence, good judgment, common sense, and confidence) were rated as being more engaged in treatment. Costa and McCrae (1992b) indicated that individuals who score high on Neuroticism are likely to have irrational ideas. They are less able to control impulses and have poor coping mechanisms. Thus, it may be helpful for clinicians to spend some time educating offenders on basic coping skills and having them practice these skills. In addition, it may be helpful to provide them with additional resources when undergoing stress. That way, the offenders will be in a more stable position to focus on and benefit from treatment. In addition, offenders should be taught to

think through their feelings and increase the rationality of their thought processes, while providing encouragement to increase their likelihood of treatment engagement.

Interventions based on Personality Factors

Researchers state that the NEO Personality Inventory may be useful to clinicians in a variety of ways. The most important potential contributions of measures of normal personality include a more comprehensive understanding of the patient and matching patients to the most appropriate treatments, based on their personality style (McCormick, Dowd, Quirk, & Zegarra, 1998). Because individuals' personalities can affect therapeutic outcome (Costa & McCrae, 1992a), the NEO-PI-R can be used to indicate intervention strategies (Piedmont & Ciarrocchi, 1999; Sanderson & Clarkin, 1994). Thus, broad based personality inventories may be useful for identifying motivational patterns that are consistent with the demands of certain treatment modalities. (Piedmont & Ciarrocchi, 1999). Muten (1991) claims that certain personality constellations and symptom presentations do better with specific treatment approaches and urges therapists to tailor treatment to specific personality dynamics to get better outcomes

Neuroticism

Obtaining a high score in Neuroticism is a characteristic expected of clinical samples (Piedmont & Ciarrocchi, 1999). Individuals who are highly neurotic are likely to seek treatment and adopt a patient role. According to Peidmont, Neuroticism is the tendency to express negative affect, such as, anxiety, depression, hostility, and high emotional distress, and is characterized by feelings of being unable to cope with stressors of life. Neuroticism is characterized by emotion instability, pessimism, fear, and low self-esteem. Thus, people high in Neuroticism often perceive themselves to be ineffective in a

variety of domains (Watson & Clark, 1984). Neuroticism also negatively predicts self-confidence in that high Neuroticism leads to low self-confidence (Carpenter, Clarkin, Isman, & Pattern, 1999). As a result, people scoring high in Neuroticism might think themselves incapable of achievement (Olson & Suls, 2000). Dwyer (1997) investigated the recidivism rates through interviews, questionnaires, and criminal records of 180 male sexual offender treatment completers from 6 months to 17 years post treatment. Over half were pedophiles. Only 9% sexually reoffended. In terms of self-esteem, the majority were proud of themselves, had a positive attitude, felt as though they were people of worth, and had improved their self-esteem. Eighty-two percent had no experiences that would put them in danger of re-offending. Dwyer claimed that low self-esteem is prominent when reoffending occurs. Thus, Neuroticism by itself is potentially prognostic of ultimate outcome (Costa & McCrae, 1992a).

Costa and McCrae (1992a) recommend that individuals who are high in Neuroticism receive long-term treatment and/or develop treatment goals that only focus on 1-2 of their multiple complaints. Highly neurotic individuals need to have more real expectations about therapy benefits. Goals should be structured to limit distress and manage symptoms versus to cure them.

Conscientiousness

Conscientiousness is also noted to affect the outcome of therapy (Costa & McCrae, 1992a). Individuals who are rated high in Conscientiousness are known to achieve success in life (Costa & McCrae, 1992a). Most important, they have motivation in goal directed behavior (Piedmont & Ciarrocchi, 1999). Those who are low in Conscientiousness tend to have a low opinion of abilities, and are unreliable, unprepared,

lacking motivation and commitment (Piedmont & Ciarrochi, 1999). Difficulty with commitment, motivation, and organization interferes with long-term goals including compliance in treatment. Because they have poorer treatment outcome, prefer to be not held responsible for behavior choices and see the cause of distress beyond their control, they need long-term work. Often with direct encouragement from a therapist, these patients can begin to become more responsible. With individuals who are characterized by low Conscientiousness, treatment goals should be simplified. It is also recommended that therapists make continued treatment congruent on completion of homework (Muten, 1991). Ultimately, these individuals need to be provided with more structure and motivation from their therapists (Costa & McCrae, 1992a; Stein & Hackerman, 1991).

In general, many clinicians may take the simple course of excluding those who are highly neurotic, less committed, and less motivated, whereas others only accept those who are motivated to change. However, excluding these patients seems to reduce the number of sex offenders eligible for treatment and may eliminate from treatment some of the most dangerous offenders (Marshall, 1994). Thus, it is important to consider the above findings and not eliminate these individuals from treatment, but provide them with treatment that matches their current functioning.

Personality and Hopelessness

In a study by Velting (1999), the relations between hopelessness and personality variables were studied. Approximately 200 participants completed the revised NEO-PI-R and the Beck Hopelessness Scale (BHS). Hopelessness was positively predicted by Neuroticism and negatively predicted by Extraversion and Conscientiousness. Neither Openness nor Agreeableness was related to Hopelessness. The finding that

Conscientiousness was found to be significantly predictive (negatively) of the Beck Helplessness Scale scores is consistent with Costa and McCrae's (1992a) characterization of individuals low in Conscientiousness as lacking in confidence, easily discouraged, and prone to quitting. In fact, more recent studies have indicated that low Conscientiousness may be associated with decreased self-efficacy, lower levels of self-reported happiness, and deficits in problem-focused coping abilities (Velting, 1999). Thus, it is not surprising that those who rate themselves as higher in Conscientiousness, and more specifically competent, are more engaged in treatment.

Personality and Relapse

Ottomanelli (1995) investigated the role that personality characteristics play in the relapse process. Approximately 108 inpatients from a chemical dependency unit participated and were assessed by the NEO-PI and followed for one year after completing of the inpatient treatment program. Two of the five NEO-PI factors were significantly related to time of relapse. Patients high in Neuroticism relapsed more quickly than patients low in Neuroticism and patients low in Conscientiousness relapsed more quickly than patients high in Conscientiousness.

In the present study, patients who rated themselves less conscientious and more neurotic had poorer engagement in treatment. The results of Ottomanelli's (1995) study lend support to the notion that these individuals are also more likely to recidivate. Given Velting's (1999) findings, it is possible that hopelessness serves as a confounding variable and may impact why individuals who are low in Conscientiousness and high in Neuroticism have lower treatment engagement and are at increased risk for recidivism.

In the present study, a hopelessness measure was not administered in order to test the relation between these variables; however, it may be something to explore in future studies. Regardless, attention should be directed at identifying patients who exhibit neurotic symptoms and who lack conscientiousness. Once identified, these patients should be worked with at a more intense level. With individuals who are considered to be less conscientiousness, finding ways to increase motivation and commitment and decrease helplessness should be important goals. With individuals who are more neurotic, interventions aimed at decreasing their negative affectivity, increasing self-esteem, and reducing their sense of helplessness should be implemented. It may be crucial not to allow offenders to graduate from treatment until these effects are observed. This may help decrease their risk of recidivism. Moreover, it will be important to find supplemental ways to increase conscientiousness and decrease neuroticism. If offenders are unable to grow to be more conscientious and less neurotic, clinicians will then need to consider if these offenders pose too much of a risk to be in the community.

Personality Factors and Treatment Engagement Variables

Extraversion

When examining specific treatment engagement items, more Extraversion was associated with worse attendance, tardiness to group, poor excuses for tardiness and/or lack of attendance, and more participation in group. A person high on Extraversion is usually known as being sociable, talkative, active, and assertive (Costa & McCrae, 1992a; Costa & Widiger, 1994). Therefore, it is reasonable that such persons would be viewed as being more active participants in group. However, it is surprising that individuals with these characteristics have worse attendance and are frequently late,

without valid reasons. It is possible that due to the nature of a more extraverted a person, the more he was noticed in terms of these dimensions. Or, it could be that the more extraverted the person is, the more outside activities he is engaging in, which makes him late or absent from treatment. In addition, the reasons he gives for tardiness or absenteeism may seem sensical to him, but not to others. Because reasons for tardiness or absenteeism from treatment were not gathered, it is difficult to verify these propositions. Furthermore, therapists who work with sexual offenders have a high alertness to people who are trying to deceive the system. It could be that the high sociability, demonstrative demeanor, and increased activity of those characterized by high Extraversion (Costa & McCrae, 1992a; Muten, 1991) may be seen as attempts to con the system. Essentially, individuals who are socially skillful are often thought of as good at manipulation and exploitation (Seto & Barbaree, 1999).

Neuroticism

Individuals who rated themselves higher on Neuroticism were rated as taking less responsibility for their offense and as being less remorseful. Because Neuroticism is characterized by emotional instability (Olson & Suls, 2000), it is reasonable that offenders would not have the ability to feel remorse for their acts. In addition, people scoring high in Neuroticism often think of themselves as incapable and have low self-confidence (Olson & Suls, 2000). These characteristics may make it difficult for them to take any ownership for their offenses, which hinders their likelihood to take responsibility for their actions.

Conscientiousness

Finally, individuals who rated themselves as high on Conscientiousness minimized their offenses less, according to their treatment providers, than those who rated themselves low on this dimension. Those who are low on Conscientiousness have a lackadaisical attitude, tend to generate more excuses, and prefer to be not held responsible for behavior choices (Muten, 1991). This is consistent with individuals low on Conscientiousness minimizing their negative behaviors.

Social Desirability and Treatment Engagement

Fifth, it was hypothesized that individuals who portrayed themselves in a positive light by endorsing socially desirable personality traits on the Paulhus Deception Scale would be rated as more engaged in treatment because they would also have portrayed a positive impression in treatment. There was no support for this hypothesis. However, in terms of specific items relating to engaging in treatment, those who utilized more impression management were rated as being less well-behaved in group, taking less responsibility for their offenses, denying a need for treatment, demonstrating lower motivation for treatment, displaying less understanding of the concepts taught in treatment, and displaying more minimization for their offenses. These results were in exact opposition to the hypothesis. The treatment providers' ability to detect those individuals who are demonstrating impression management might account for such findings. Because sexual offenders are known to be deceptive (Sewell & Salekin, 1997), treatment providers may be suspicious of those who appear too good to be true.

Nugent and Kroner (1996) offer another explanation for these results. They examined the correspondence of measures of denial and response styles with the level of

admittance of offense among 49 child molesters and 49 rapists using the Balanced Inventory of Desirable Responding, now known as the Paulhus Deception Scale, and the Basic Personality Inventory. They found that child molesters who admitted their offense incorporated more denial and impression management tactics than admitting rapists. Overall, they found elevated impression management scores of child molesters. Nugent and Kroner suggest that for child molesters, denial and lying may be an ingrained pervasive response that has little relation to whether they admit their offense. Thus, measures of denial and response style may provide little information concerning the validity of their disclosure. The authors also suggest that the lack of correspondence between self-report and offense disclosure implies that the offender's self-presentation in the context of treatment may be independent of his willingness to accept responsibility or motivation to alter his behavior. They suggest that impression management reflects deeply ingrained defense mechanisms or automatic egotism (i.e., an inflated ego that occurs automatically as a defensive response to threat) that child molesters are largely unaware of. Because child molesters may be largely unaware of the presence and extent of their denial, the authors suggest that such defensiveness will be resistant to treatment.

Study Limitations

One limitation of the study was the size of the sample. Some results demonstrated marginally significant trends. However, it is possible that with more participants, results would have been more robust.

Another limitation was the time it took for the treatment providers to fill out the evaluation forms to assess participants' treatment engagement. After participants filled out both sets of questionnaires, the treatment providers were given the EVAL-O's. The

treatment providers were instructed to take two weeks to complete these forms. However, they were unable to complete the forms within this time frame. Consequently, some of the participants were not rated on treatment variables until 3 months after they completed their questionnaires. This is of particular concern because engagement in treatment is likely to change over time. Earlier analysis demonstrated that a longer time in treatment was associated with more engagement in treatment. Thus, a different pattern of results may have emerged had offenders been rated at an earlier date. Further, there is some concern that treatment engagement may have been viewed by raters as an overall variable of treatment progress, versus rating the offenders' on the characteristics they possessed at that particular moment in time. In addition, rating clients retrospectively is difficult to do. Even if treatment providers were trying to rate clients as appeared at an earlier date, there is a high likelihood that the counselors may have been unable recall their exact characteristics, leading to an inaccurate rating. Given this, the validity of the EVAL-O data must be evaluated cautiously.

A further limitation of the study was its limited scope. The findings are only generalizable to men who have committed a child sexual offense. In addition, the sample is limited to outpatient child molesters. It is possible that outpatient and incarcerated offenders have dissimilar views about themselves and about a typical child molester.

One drawback of using self-report data in forensic settings is the likelihood of deception. For example, the majority of status variables that were used in the study, such as number of children abused, were gathered from the patients' self-report records. Moreover, there were no mechanisms or attempts to verify such status variables. Thus, caution must be taken when examining demographic and other status information.

Self-ratings on the NEO-PI-R were to be reported to the offenders' treatment providers and kept in their files. Thus, participants may have been more likely to present themselves in a positive light, knowing their data were not completely anonymous.

Using self-report questionnaires meant that individuals were required to meet the reading level requirements dictated by the instruments. This eliminated several potential participants. Therefore, results may have been affected by including only child molesters who had a 6th grade reading level or above. Likewise, selected individuals voluntarily participated in the research study. As with any voluntary project, the individuals who choose to participate may be inherently different from those who do not choose to participate. Thus, results may not be fully generalizable to all sexual offenders in outpatient treatment for a child sexual offense.

In addition, self-report scales are transparent and therefore, subject to response bias. The items on the NEO-PI-R are obvious, asking directly about what they are measuring and are relatively crude measures of deviant beliefs and behaviors (Costa & McCrae, 1992a). They assume a stability, generality, and accessibility of beliefs, which may not always be true (Ward, Hudson, Johnston, & Marshall, 1997). Costa and McCrae (1992a) state that one needs trust, interest, and cooperation to have a successful assessment. Although there was interest and cooperation in the study, there was no rapport or trust built with the participants. It is important to note that scores on self-report measures are sometimes distorted by response styles and sets and that individuals lack insight into their own personalities (Costa & McCrae, 1992a).

Further, the variables that were gathered relating to engagement in treatment were based on the subjective ratings of the treatment providers. To date, no research has

indicated what the best measures for treatment engagement may be. Further, there is little information indicating what the relationship may be between treatment engagement (from the perspective of treatment providers) and rates of future reoffense.

Caution must be used when interpreting results linked with treatment engagement because a halo effect may have occurred when treatment providers rated offenders on the EVAL-O. The halo effect states that extreme scores on one rating will affect subsequent scores in the same direction. Therefore, an extreme negative rating on an item will bias the next several items in a negative direction. The effect also holds for extreme positive ratings (“Studying Personality,” 2001). Viewing an offender as intelligent was significantly positively related to 14 out of 15 variables which measured treatment engagement. Thus, the more an offender was viewed as intelligent, the better he was rated on various dimensions measuring engagement in treatment. Similarly, having a negative reaction to an offender was significantly negatively related to all 15 variables of treatment engagement. Thus, having a negative reaction to an offender was related to the offender doing less well on all measures of treatment engagement.

Last, this study is somewhat limited in that comparisons of the offenders’ scores on the NEO-PI-R were made with the normative sample, based on a non-clinical population. Thus, it would be interesting to see how offenders’ views compare to other clinical populations.

Clinical Implications

First, there has been no controversy in regard to the negative image that child molesters hold in our society. However, it was unclear before this study what child molesters’ perceptions would be of a “typical” child molester. Interestingly, sexual

offenders in this study also viewed a typical child molester in a negative light, consistent with the view held by society. This means that sexual offenders believe, perhaps like the general public, that individuals who perpetrate sexual offenses against children have personality traits that are extreme, falling outside of the normal range of personality functioning.

This study also discovered that most child molesters see themselves significantly different from even their own view of a typical child molester. Although sexual offenders rated themselves, on average, negatively in terms of Conscientiousness and Neuroticism, they rated themselves, on all scales, more positively than a typical child molester. Thus, they did not internalize the negative views they held about typical child molesters. Several reasons were proposed for why this occurred. One potential reason includes attributing personal behaviors to external causes versus internal traits (Blumenthal, Gudjonsonn, & Burns, 1999). Seeing one's actions as a result of situational occurrences also encourages offenders away from seeing their actions as driven by global dispositions (Nisbett et al., 1973). In addition, people who see themselves as more differentiated endorse less consistent global personality traits (Mirels et al., 1998). It could also be that offenders feel their crimes are not as severe as other child molesters' because they are in treatment and not in jail or prison. In fact, this may be true. In addition, they may be trying to avoid a negative self-stigma. Whatever the reason, seeing oneself in a positive light or a more normalized view may allow offenders to escape the negative feelings of being like a "typical" child molester. Because of this, they may feel that they have some promise of being helped, unlike that of a typical offender. If sexual offenders were to

view themselves as strongly and negatively as they view a typical child molester, it does not seem that they would have much confidence or motivation to change or improve.

In general, sexual offenders who participated in this study rated themselves as being average on a variety of personality factors: Extraversion, Openness to Experience, and Agreeableness. However, they also rated themselves moderately high on Neuroticism and moderately low on Conscientiousness. These results reflect that the child molesters in this study are taking some responsibility for thinking irrationally and being less able to control impulses. They also viewed themselves as more lackadaisical in terms of working towards their goals and acting without considering the consequences of their actions. Surprisingly, they do not see themselves as necessarily reserved, which is a common perception of sexual offenders.

It is recommended that clinicians maintain realistic expectations of individuals who see themselves as irrational and neurotic. It is best to develop a small number of treatment goals and help them with their distress. Clinicians should refrain from thinking these offenders will be cured and should help them manage their behaviors (Costa & McCrae, 1992a). When working with offenders, treatment goals should be simplified (Muten, 1991). Therapists should also try to maintain high structure in the treatment and use different techniques to motivate them (Costa & McCrae, 1992a; Stein & Hackerman, 1991).

According to the results of this study, how a sexual offender views himself in relation to a typical child molester does not seem to have an effect on his engagement in treatment. Thus, convincing offenders that they are representative of a "typical" child molester may not help his overall level of success in the treatment program. In general,

self-perceptions related to how similar or different a person feels he is to a typical child molester do not have any effect on his level of responsibility, desire for help, or motivation for recovery. According to Pribyl (1988), other factors, such as being aware of how one's thoughts relate to feelings and behaviors, fear of consequences, level of empathy for victims, and level of honesty have more to do with progress in treatment. Based on these, therapists should encourage clients to acknowledge discrepancies and similarities between what they say, do, and feel. The consequences of behaviors should be talked about and honest introspection should be encouraged. In addition, goals that include the development of empathy for victims should be discussed.

A longer time spent in treatment also does not influence a child sexual offender to see himself more similarly to a typical child molester. However, a longer time in treatment was associated with more overall treatment engagement, providing that offenders are being honest in their self-presentation. Basically, it is important to find out what factors may contribute to those who remain in treatment for an extended period of time. A treatment provider may then utilize those as well as variables that relate to treatment engagement to enhance an individual's treatment.

On the other hand, how a sexual offender views himself in relation to a typical child molester is related to the number of victims that an offender perpetrates against. The most significant finding in this study was that offenders who view themselves similarly to a typical child molester on Conscientiousness and dissimilar from a typical molester in terms of Agreeableness tended to have a larger number of reported victims. Thus, offenders who believe they are more trustworthy than a typical molester, yet also view themselves as lower in Conscientiousness (meaning they are laidback and

unreliable) are likely to have perpetrated against more victims. However, only those who proved to be non-deceptive exhibited this relation. Thus, it is important to be cautious when working with highly deceptive individuals, as their dishonesty may extend to other areas. Because individuals with an extensive sexual history are at greater risk for re-offense, these individuals may also be more at risk for re-offending. Thus, greater attention should be given to individuals who display these types of characteristics.

Individuals who considered themselves as low in terms of Neuroticism and high in Conscientiousness are more engaged in treatment than individuals who show the opposite pattern. People who feel that they are highly neurotic may not have the cognitive abilities to comply with treatment. This study found that individuals high in Neuroticism tend not to take responsibility for their offenses or have remorse for their victims. Thus, they may have difficulty seeing that what they did was wrong and may externalize blame. Individuals who are less conscientious tend to minimize their offenses more often. If treatment sites have a shortage of space and need to make decisions about which individuals to treat, these findings, if replicated, may assist in evaluating who will benefit most from treatment. On the other hand, excluding those who are highly neurotic or not very conscientious may eliminate the offenders who need treatment the most (Marshall, 1994). Thus, it is recommended that therapists use different strategies in working with these offenders in which they match interventions to the offenders' personality characteristics. It may be helpful for clinicians to spend some time educating offenders on basic coping skills and having them practice these skills. Offenders should be taught to think through their feelings and increase the rational thought processes. These strategies may help offenders become more engaged in treatment.

Although it might seem logical that consistently presenting oneself in a positive light may lead to better perceived treatment engagement, there was no support for this proposition in the present study. In fact, individuals who used more impression management were rated as doing less well in treatment on various dimensions. Thus, it appears that sexual offenders who present themselves most positively do not act in accordance with these views and are detected by the treatment providers. Because those who display a positive impression are likely to do less well in treatment, clinicians should focus on actuarial data to prevent themselves from being influenced by their presentation in treatment. Oftentimes, therapists may feel encouraged when attendees become and remain fully cooperative participants in the treatment process (Hanson, 1997). Therefore, it may be useful for treatment providers to be alert to aspects of an offender's presentation that signify he is actually doing well in treatment versus simply creating a positive impression.

Future Research

Based on logical analysis, it seems reasonable to suspect that individuals who are more engaged in treatment will be less likely to recidivate than individuals who are not performing well. However, this is an empirical question that is not yet answered. According to Hanson and Bussiere (1996), almost all the empirically validated risk factors for sexual offenders are static historical variables, such as age and offense history. Traditionally, investigators have estimated the probability of relapse using static variables such as violence of the actual offense (Rice, et al., 1991), the number of previous convictions (Hanson et al., 1992; Hall, 1988), time spent in custody (Rice et al., 1991) or various traumatic events in the offender's childhood (Berner & Karlick-Bolten, 1986,

cited in Freuwald et al., 1998). All of these parameters are important for the assessment of dangerousness, but unfortunately none of them can be changed by therapy (Fruehwald et al., 1998). According to Hanson (1997), the most dynamic of the empirically validated risk factors are motivation and cooperation with treatment. This study was a first step in attempting to measure variables which revolved around these factors and which measured overall treatment engagement, yet found few significant results.

Thus, the first area of future study should be to determine which dynamic treatment variables may be linked with treatment engagement. Hanson (1997) claims that within-therapy change on clinically relevant variables will be the primary information used to guide the development of sexual offender treatment programs. Although recidivism reduction is the ultimate goal of treatment, recidivism information accumulates slowly. Thus, exploring within- treatment variables that may relate to recidivism rates is a necessary first step (Geer, Estupinan, & Manguno-Mire, 2000). Within-treatment changes on dynamic (changeable) risk factors are immediate indicators of treatment effectiveness (Hanson, 1997). Within-treatment changes, unlike recidivism, are easily observed, can be replicated across settings and individuals, and can be closely linked to specific theories of sexual offender treatment. In practice, such within-treatment changes are all that most sexual offender therapists have to work with.

When examining within-treatment changes, it is also crucial to extend research on cognitive distortions in sexual offending, as done in this study, to include a greater range of cognitive variables rather than simply measuring distorted attitudes or beliefs (Ward, Hudson, et al., 1997). Variables in addition to self-perception of personality factors should be investigated for their relation with treatment engagement. Pribyl (1998) has

investigated what factors contribute to sexual offenders' treatment engagement. He found that telling the truth, fear of consequences, victim empathy, and awareness of the relations between thoughts, feelings, and behaviors were all significant predictors of progress. Thus, it is important to focus on these variables to determine if they have replicable relations to treatment engagement, and to determine if they can predict recidivism.

While future research investigates various correlates of treatment engagement, it will also be essential to determine how treatment engagement relates to sexual recidivism. As stated by Criassati and McClurg (1997), certain variables may indicate a poor prognosis in terms of treatment compliance, yet it is not yet clear whether noncompliance is an accurate predictor of sexual reoffending. Within-treatment changes will be meaningful only when the variables targeted are linked to recidivism. Thus, the analysis of within-treatment changes must be accompanied by the follow-up research needed to determine whether the factors are indeed recidivism risk factors (Hanson, 1997; Pithers, 1994). Determining which factors are generally associated with recidivism requires reliable assessments, large sample sizes, and replicable results. It is only over longer periods of time that the validity ratings of compliance/noncompliance as predictors of reoffending can be determined (Craissati & McClurg, 1997). Once a set of reliable risk factors have been identified, changes on these risk factors can be used to assess the impact of treatment on individual offenders. In other words, programs can monitor their own efficacy through the analysis of within-treatment change on dynamic risk factors (Hanson, 1997).

A useful next study building on the present study would include data from incarcerated sexual offenders, especially because incarcerated offenders have been noted to make less progress in treatment. In addition, incarcerated offenders likely have thoughts about themselves and others that may differ from nonincarcerated offenders (Horley & Quinsey, 1994).

After looking at how 215 institutionalized child molesters and 143 child molesters from the community rated themselves on their ideal and real selves, Frisbie and colleagues (1967) concluded that the pedophiles in the community, compared to those who were institutionalized, saw a greater relation between their ideal self and real self. From this, Frisbie and colleagues suggested that sexual offenders in the community were better integrated than those in institutions. Because incarcerated offenders may represent a subset of more severe perpetrators, investigating their responses in comparison to individuals who are in outpatient treatment may lead to additional findings that could not be derived from this study.

In addition, the NEO-PI-R is a sound measure with high test-retest reliability. However, features in the FFM have been shown to change for clinical samples that experience benefits from treatment (Piedmont & Ciarrocchi, 1999). Nevertheless, some of the personality dimensions have been prone to change, whereas others tend to be more stable over time. Several studies have shown changeability on the Neuroticism, Extraversion, and Conscientiousness scales, but stability on the Openness and Agreeableness subscales (Bagby, Levitan, Kennedy, Levitt, & Joffe, 1999; Jain, Blais, Otto, Hirshfeld, & Sachs, 1999; Lannoo, De Deyne, Colardyn, De. Soete, & Jannes, 1997). Thus, although there is a possibility for change on the NEO factors from

psychotherapy, it is important to investigate whether sexual offenders are likely to change their views either of themselves or of a typical child molester. This will help professionals understand how these factors are longitudinally affected by treatment.

In addition to a self-report, a future study may consider using a structured interview, such as the Structured Interview for the Five-Factor Model of Personality; Trull & Widiger, 1997) to minimize self-report biases. The SIFFM would be an appropriate measure because it is closely modeled after the NEO-PI-R, assessing the five bipolar personality dimensions of the Five-Factor Model, and allows the professional to ask probes and follow-up questions as needed.

Summary and Conclusions

Researchers have emphasized the important role of cognitions in child sex offenders' molesting behaviors. Although cognitions have been recognized as a primary component in the treatment of child molesters, little research has examined child molesters' thoughts about themselves in relation to their treatment engagement. In this study, the NEO-Personality Inventory (NEO-PI-R) was administered to 67 child molesters who were in outpatient treatment for a child sexual offense. Child sexual offenders rated themselves on the NEO-PI-R and rated their view of a typical child molester using a revised, but parallel version of the NEO-PI-R. The present study investigated the degree to which child sex offenders identify themselves with their view of a typical child molester, and this agreement's relation with treatment engagement .

Child sexual offenders rated a typical child molester, overall, in a negative light on five different personality factors. Moreover, they rated themselves more positively on the same five dimensions. Thus, child molesters in treatment have negative views of child

sex offenders that are not consistent with their own self-perceptions. The discrepancy between how a child molester views himself and how he views a typical child molester does not have demonstrable impact on his treatment engagement, as rated by his treatment providers. In addition, the length of time spent in treatment does not relate to his self-perceptions in this area. However, how a child molester views himself in relation to a typical child molester does relate to how many victims he has perpetrated against. For example, those who believe they are similar to a typical offender in terms of Conscientiousness and dissimilar in Agreeableness perpetrate against more victims. Thus, to prevent further molestation, it may be important to focus on these self-perceptions.

Child molesters who are high on Neuroticism and low on Conscientiousness had poor treatment engagement. Therefore, individuals who display these types of characteristics may not be good candidates for treatment. However, approaches for working with these individuals in treatment can be modified so interventions match their personality characteristics. Engaging in impression management may be a pervasive problem for child molesters in general; however, it does not seem to affect how his engagement in treatment is perceived by treatment providers. In other words, treatment providers do not seem to be swayed into thinking offenders are performing adequately simply because they provide a positive impression in treatment.

In sum, treatment programs include components that target cognitive distortions (i.e., the attitudes and beliefs or self-statements which offenders use to deny, minimize and rationalize their behavior) because many believe that it is necessary for offenders to change the way they think about their offending behavior in order to be sufficiently motivated to benefit from therapy (Ward, Hudson, et al., 1997). A fundamental

assumption of cognitive-behavioral approaches is that these attitudes and underlying belief systems perform a major role in precipitating and maintaining sexual offending behavior (Abel et al., 1984; Stermac & Segal, 1989). Addressing attitudes and beliefs is regarded as an important component of most therapeutic interventions, yet there has been little research between distorted attitudes and beliefs and treatment engagement (Blumenthal et al., 1999). Additionally, most of the research on the cognitions of sex offenders has concentrated on distortions. This study was one of the first that attempted to expand the research on cognitive factors by examining perceptions of self in relation to engagement in treatment. Future studies in this area should continue to examine factors that may relate to treatment engagement and then study how these factors relate to recidivism.

APPENDIX A

TABLES

Table 1

Descriptive Statistics for Continuous Demographic and Status Variables

Variable	N	Minimum	Maximum	Mean	SD
Age	67	18	76	43.15	11.20
Years of Education	66	3	18	12.64	2.63
Years in Treatment	67	.2	12.50	4.31	2.68
Yearly Income	65	0	100,000	30,381.60	19,191.02
Children Abused	66	1	48	3.97	8.11
Warnings for Dismissal	67	0	65	7.88	13.53
Notices of Termination	67	0	4	.22	.65
Polygraph Failures	67	0	4	.82	1.04

Table 2

Descriptive Statistics for Categorical Demographic and Status Variables

Variable	Categories	FREQUENCY		Percent
Ethnicity	Caucasian	51		76.1
	Hispanic	8		11.9
	African American	2		3.0
	Native American	2		3.0
	Asian/Pacific Islander	2		3.0
	Other	2		3.0
Educational Level	Did not complete high school	11		16.4
	High School Diploma/GED	24		35.8
	Some college	22		32.8
	College degree	10		14.9
Religious Orientation	Protestant	22		32.8
	Baptist	12		17.9
	Catholic	10		14.9
	Other	13		19.4
	None	10		14.9
Marital Status	Never Married	11		16.4
	Married/Living as Married	31		46.3
	Separated	6		9.0
	Divorced	19		28.4
Sexual Preference	Heterosexual	59		88.1
	Homosexual	2		3.0
	Bisexual	5		7.5
Time in Treatment	Less than one year	10		14.9
	1-3 years	13		19.4
	3-6 years	28		41.8
	Over 6 years	15		22.4
Source of Treatment	Probation	52		77.7
	Parole	8		11.9
	Referral	5		7.5

Table 2

Descriptive Statistics for Categorical Demographic and Status Variables (Cont'd)

Variable	Categories	FREQUENCY		Percent
<hr/>				
Number of Victims	One	39		59.1
	2-6	21		31.3
	15 or more	6		9.0
Relationship of Victim	Extrafamilial	18		26.9
	Intrafamilial	34		50.7
	Both extrafamilial and intrafamilial	14		20.9
Warnings for Dismissal	None	24		35.8
	1-5	24		35.8
	6-20	9		13.4
	Over 20	10		14.9
Notices of Termination	None	57		85.1
	1	7		10.4
	2	2		3.0
	4	1		1.5
Polygraph Failures	None	35		52.2
	1	15		22.4
	2	13		19.4
	3 or more	4		6.0
Payments	Up to date	39		58.2
	Not up to date	28		41.8

Table 3

Inter-correlations of the 5 NEO-PI-R Factors, Self-Ratings

	NS	ES	OS	AS	CS
Neuroticism, Self Rating (NS)	--	-.11	.10	-.60**	-.53**
Extraversion, Self Rating (ES)		--	.38**	-.02	.34**
Openness, Self Rating (OS)			--	-.11	-.04
Agreeableness, Self Rating (AS)				--	.47**
Conscientiousness, Self Rating (CS)					--

Note. * = $p \leq .05$, ** = $p \leq .01$

Table 4

Inter-correlations of the 5 NEO-PI-R Factors, Typical Ratings

	NT	ET	OT	AT	CT
Neuroticism, Typical Rating (NT)	--	.01	.30*	-.62**	-.56**.
Extraversion, Typical Rating (ET)		--	.40**	.13	.13
Openness, Typical Rating (OT)			--	.04	-.12
Agreeableness, Typical Rating (AT)				--	.53**
Conscientiousness, Typical Rating (CT)					--

Note. * = $p \leq .05$, ** = $p \leq .01$

Table 5

Inter-correlations of the 5 NEO-PI-R Factors, Self-Ratings and Typical Ratings

	NT	ET	OT	AT	CT
Neuroticism Self-Ratings (NS)	.22				
Extraversion Self-Ratings (NS)		.34**			
Openness Self-Ratings (OS)			.56**		
Agreeableness Self-Ratings (AS)				.24*	
Conscientiousness Self-Ratings (CS)					.25*

Note. * = $p \leq .05$, ** = $p \leq .01$

Table 6

Perceptions of a Typical Child Molester

Variable	Norms	One-Sample T-test	Paired Sample T-tests
Neuroticism	High	High	A
Extraversion	Average	Low	B
Openness	Average	Low	B
Agreeableness	Low	Low	C
Conscientiousness	Low	Low	C

Note. One Sample T-test = Computed between each of the mean scores and the average scores from the standardization sample of individuals who completed the NEO-PI-R.

Paired Sample T-test= All 5 factors were analyzed in comparison to each other. Common letters under Paired Sample T-tests indicate non-significant differences.

Table 7

Inter-correlations of the 5 NEO-PI-R Factor Difference Scores

	TE	N?	E?	O?	A?	C?
Neuroticism Difference (N?)		--	.15	.22*	.68**	.62**
Extraversion Difference (E?)			--	.08	.15	.21*
Openness Difference (O?)				--	.30**	.18
Agreeableness Difference (A?)					--	.69**
Conscientiousness Difference (C?)						--

Note. * = $p \leq .05$, ** = $p \leq .01$

Table 8

Inter-correlations of the 5 NEO-PI-R Factor Difference Scores and Treatment Engagement

	TE	N?	E?	O?	A?	C?
Treatment Engagement (TE)	--	.10	.16	-.09	-.01	.02

Regression Overall

R	R ²	Adjusted R ²	F	df	p
.232	.054	-.024	.694	5, 61	.630

Predictors

Variable	Beta	t-value	p
Neuroticism Difference	.18	1.03	.305
Extraversion Difference	.17	1.31	.194
Openness Difference	-.11	.82	.416
Agreeableness Difference	-.10	.48	.635
Conscientiousness Difference	-.04	.23	.816

Note. * = $p \leq .05$, ** = $p \leq .01$

Table 9

Inter-correlations of the 5 NEO-PI-R Factor Difference Scores and Time in Treatment

	T	N?	E?	O?	A?	C?
Time in Treatment (T)	--	.07	-.05	-.10	-.04	.04

Regression Overall

R	R ²	Adjusted R ²	F	df	p
.18	.03	-.05	.41	5, 61	.84

Predictors

Variable	Beta	t-value	p
Neuroticism Difference	.15	.83	.412
Extraversion Difference	-.06	.45	.657
Openness Difference	-.10	.76	.448
Agreeableness Difference	-.16	.81	.424
Conscientiousness Difference	.09	.49	.624

Note. * = $p \leq .05$, ** = $p \leq .01$

Table 10

Inter-correlations of the 5 NEO-PI-R Factor Difference Scores and Number of Victims

	V	N?	E?	O?	A?	C?
Number of Victims (V)	--	-.20**	-.20*	.10	.24*	-.14

Regression Overall

R	R ²	Adjusted R ²	F	df	p
.54	.30	.24	5.03	5, 60	.001

Predictors

Variable	Beta	t-value	p
Neuroticism Difference	.26	1.71	.092
Extraversion Difference	-.19	1.69	.097
Openness Difference	.02	.16	.876
Agreeableness Difference	.50	2.94	.005**
Conscientiousness Difference	-.60	3.83	.000***

Note. * = $p \leq .05$, ** = $p \leq .01$ *** = $p \leq .001$

Table 11

Correlations between Self-Ratings on the 5 NEO-PI-R Factors, Overall TreatmentEngagement, and Specific Items Pertaining to Treatment Engagement

	N	E	O	A	C
Overall Engagement	.20*	-.01	.04	.12	.19*
Good Attendance	-.14	-.21**	-.03	.14	.12
Punctuality	-.08	-.30***	-.10	.13	.07
Good Excuses	-.01	-.29***	-.08	.11	-.00
High Participation	-.19	.20**	-.10	.05	.18
Responsibility	-.21**	.14	-.03	.03	.12
Remorseful	-.21**	.02	.08	.12	.14
Low Minimization	-.20	.07	.10	.06	.21**

Note. * = $p \leq .07$, ** = $p \leq .05$, *** = $p \leq .01$

Table 12

Correlations between Clinicians' Ratings of Sex Offenders as Intelligent and Negative Reaction Ratings with Overall Treatment Engagement and Specific Items Pertaining to Treatment Engagement

	Intelligence	Negative Reaction
Overall Engagement	.57**	-.31*
Good Attendance	.26*	-.48***
Punctuality	.29*	-.48***
Good Excuses	.24*	-.50***
Completes homework	.54***	-.40***
High Participation	.55***	-.25*
Attentive	.32**	-.52***
Well Behaved	.05	-.42***
Denial	.40***	-.54***
Lack of Minimization	.59***	-.58***
Responsible	.53***	-.50***
Remorse	.59***	-.57***
Admits Treatment	.40***	-.45***
Motivated for Treatment	.43***	-.57***
Changed behaviors	.29*	-.34*
Understands concepts	.68***	-.62***

Note. * = $p \leq .05$, ** = $p \leq .01$, *** = $p \leq .001$. Intelligence and Negative Reaction refer to the last two EVAL-O questions. Other items are from the treatment engagement index.

APPENDIX B
RATING FORM

APPENDIX B

EVALUATION OF OFFENDER (EVAL-O)

Name of Client: _____ Today's Date: _____

This instrument is used to assess the treatment engagement of an individual who has been convicted of a sexual offense. For each item, please circle the number that best describes your client.

0=Unable to ascertain 1=Strongly Disagree 2=Disagree 3=Agree 4=Strongly Agree

Client has good attendance.

1 2 3 4

Client frequently arrives late.

1 2 3 4

Client has acceptable excuses for missing session(s) and/or arriving late.

1 2 3 4

Client consistently completes homework.

1 2 3 4

Client seems preoccupied, uninvolved, and uninterested in treatment.

1 2 3 4

Client actively participates during group.

1 2 3 4

Client is poorly behaved during group (e.g., rude, disrespectful, disruptive, etc.).

1 2 3 4

Client is in denial regarding important aspects of offending behavior.

1 2 3 4

Client takes responsibility for sexual offenses.

1 2 3 4

Client minimizes sexual offenses.

1 2 3 4

Client believes he needs treatment.

1 2 3 4

Client appears to understand concepts taught in group.

1 2 3 4

Client expresses genuine remorse for the pain/suffering caused to his victim(s).

1 2 3 4

Client has changed his behavior to minimize re-offense
(e.g., removes self from risky situations).

0 1 2 3 4

Client shows motivation for treatment/recovery.

1 2 3 4

Client appears intelligent.

1 2 3 4

I often have a negative reaction to this client.

1 2 3 4

THANK YOU FOR YOUR TIME!

APPENDIX C
CONSENT FORM

APPENDIX C

University of North Texas

CONSENT FORM FOR PARTICIPATION IN STUDY

You are being invited to voluntarily participate in a research project intended to learn more about patients who are in treatment for a child sexual offense. Participation in this study will involve 2 sessions of filling out questionnaires during your regular group treatment sessions. Your participation is entirely voluntary and is not part of your care at this treatment center. If you stop while the study is underway, or if you refuse to participate altogether, the care you receive from your therapist will not be affected.

I, _____, voluntarily agree to participate in a study on personality characteristics of individuals who are receiving treatment in relation to a child sexual offense. I understand that I will take two self-report measures of personality. Before I begin, I will be administered a brief reading test to ensure that I am eligible to participate. I will also be asked to fill out some basic information about myself. I agree to give permission for my file at this treatment center to be reviewed for background and treatment information. I also give permission for my therapist to answer questions indicating my progress in treatment. I understand that I will be filling out questionnaires on two separate occasions, two weeks apart, during my regular group session times. The total time for participation in this study will be approximately two hours.

My answers to questions regarding my personality, on the first day of testing, will be reported to my treatment provider. However, my responses on the second day of testing will be strictly confidential and used for research purposes only. During the second day of testing, I understand that my name will not appear attached to any information I give. Only a code number will appear on these forms. A list linking my name to my identification number will be kept in a locked file cabinet and will be destroyed when data collection is complete. I understand that my name will not appear in any publication of the results of this study.

The information obtained in this study may be used to help develop more effective sex offender treatment strategies. The risks of participation are considered minimal. I may benefit from this study by having additional clinical data available to my treating clinician. One small risk is that answering some questions may bring up issues about myself that are troubling to me; If that happens, I understand I will have access to therapy services within the treatment center. I also understand that I am free to withdraw my consent and discontinue participation in this study at any time. A decision to withdraw from the study will not affect the treatment or services available to me.

I have read and understand the information on this form and I will receive a copy of it. I volunteer to participate based on this information.

(Signature of Participant)

(Witness and/or Principal Investigator)

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APPENDIX D
RECORD FORM

APPENDIX D

RECORD FORM

Name of Client_____ ID #_____

_____Number of child victims

Children abused were:

_____ Extra-familial only

_____ Intra-familial only

_____ Both

_____ Number of Warnings for dismissal

_____Number of polygraphs administered

_____Number of polygraphs failed

_____Payments are up to date (0=Yes, 1=NO)

APPENDIX E
DEMOGRAPHICS FORM

APPENDIX E

DEMOGRAPHICS

Name _____ ID# _____

_____ Date of Birth

_____ Ethnicity:

1=Caucasian 2=African American 3=Hispanic
4=Native American 5=Asian/Pacific Islander 6= Other (specify) _____

_____ Highest grade you reached in High School

_____ Amount and type of other education.

_____ Religious Affiliation:

1= Catholic 2= Protestant 3 = Muslim
4= Jewish 3=None 5 = Other (specify) _____

_____ Marital Status

1=Married or Living as Married 2=Separated 3=Divorced
4=Widowed 5=Never Married

_____ Sexual Orientation

1=Heterosexual 2=Homosexual 3= Bisexual

_____ Length of Time in Treatment

_____ Means by which treatment was sought:

1= probation
2= parole
3= referral (e.g., by family member, friend, counselor, doctor, agency)
4= Other _____

\$_____Yearly Income

_____Most Recent Occupation

REFERENCES

Abel, G. G., Becker, J. V., & Cunningham-Rathner, J. (1984). Complications, consent, and cognitions in sex between children and adults. International Journal of Law and Psychiatry, 7, 89-103.

Abel, G. G., Becker, J. V., Mittelman, M. S., Cunningham-Rathner, J., Rouleau, J. L., & Murphy, W. D. (1987). Self-reported sex crimes of nonincarcerated paraphilics. Journal of Interpersonal Violence, 2, 3-25.

Alexander, M. A. (1999). Sexual offender treatment efficacy revisited. Sex Abuse, 11, 101-116.

American Psychiatric Association (1994). Diagnostic and statistical manual of mental disorders. 4th ed. Rev. Washington, D.C.: author.

Association for the Treatment of Sexual Abusers (1996, November 6). Reducing Sexual Abuse Through Treatment and Intervention with Abusers. [brochure]

Bagby, R. M., Levitan, R. D., Kennedy, S. H., Levitt, A. J., & Joffe, R. T. (1999). Selective alteration of personality in response to noradrenergic and serotonergic antidepressant medication in depressed sample: Evidence of non-specificity. Psychiatry Research, 86, 211-216.

Bahn, C., & Davis, J. (1991). Social-psychological effects of the status of a probationer. Federal Probation, 17-23.

Barbaree, H. E. (1991). Denial and minimization among sex offenders: Assessment and treatment outcome. Forum on Corrections Research, 3, 30-33.

Barbaree, H., & Marshall, W. (1988). Deviant sexual arousal, offense history and demographic variables as predictors of reoffense among child molesters. Behavioral Sciences and the Law, 6, 267-280.

Becker, J. V. (1994). Offenders: characteristics and treatment. Sexual Abuse of Children, 4, 176-197.

Beech, A., & Fordham, A. S. (1997). Therapeutic climate of sexual offender treatment programs. Sexual Abuse: A Journal of Research and Treatment, 9, 219-237.

Berner, W., & Karlick-Bolten, E. (1986). Verlaufsformen der Sexualkriminalitaet. (Treatment of the sexual criminal). Wien: Enke.

Blumenthal, S., Gudjonsson, G., & Burns, J. (1999). Cognitive distortions and blame attribution in sex offenders against adults and children. Child Abuse and Neglect, 23, 129-143.

Briggs, F., & Hawkins, R. M. F. (1996). A comparison of the childhood experiences of convicted male child molesters and men who were sexually abused in childhood and claimed to be nonoffenders. Child Abuse and Neglect, 20, 221-233.

Briley, J., (2000). The uninvestigated factors: Dimensions of personality and psychopathology in sex offenders. Unpublished master's thesis. University of North Texas, Denton, Texas.

Bumby, K. M. (1996). Assessing the cognitive distortions of child molesters and rapists: Development and validation of the MOLEST and RAPE scales. Sexual Abuse: A Journal of Research and Treatment, 8, 37-54.

Carpenter, D., Clarkin, J. F., Isman, L., & Pattern, M. (1999). The impact of neuroticism upon married bipolar patients. Journal of Personality Disorders, 13, 60-66.

Cattell, R. B., Eber, H. W., & Tatsuoka, M. M. (1970). The Handbook for the Sixteen Personality Factor Questionnaire. Champaign, IL: Institute for Personality and Ability Testing.

Clark, L. E., Vorhies, L., & McEwan, J. L. (1990). Personality disorder symptomatology from the five-factor model perspective. In P. Costa & T. A. Widiger (Eds.), Personality disorders and the five-factor model of personality (pp. 95-116). Washington, D.C.: American Psychological Association.

Conte, J. R. (1986). A look at child sexual abuse. South Deerfield, WA: National Committee on the Prevention of Child Abuse.

Cook, M., & Howells, K. (Eds.). (1981). Adult sexual interest in children. New York: Academic Press.

Costa, P. T., & McCrae, R. R. (1992a). Normal personality assessment in clinical practice: The NEO personality inventory. Psychological Assessment, 4, 5-13.

Costa, P. T. Jr., & McCrae, R. R. (1992b). Revised NEO Personality Inventory (NEO-PI-R) and NEO Five Factor Inventory (NEO-FFI): Professional manual. Odessa, FL: Psychological Assessment Resources.

Costa, P. T., & Widiger, T. A. (1994). Introduction: Personality disorders and the five-factor model of personality. In P. Costa & T. A. Widiger (Eds.), Personality disorders and the five-factor model of personality (pp. 1-10). Washington, D.C.: American Psychological Association.

Craissati, J., & McClurg, G. (1997). The challenge project: A treatment program evaluation for perpetrators of child sexual abuse. Child Abuse and Neglect, 21, 637-648.

Dwyer, S. M. (1997). Treatment outcome study: Seventeen years after sexual offender treatment. Sexual Abuse: A Journal of Research and Treatment, 9, 149-160.

Edwards, A. L. (1959). Edwards Personal Preference Schedule Manual. New York: Psychological Corporation.

Engel, B. (1989). The right to innocence, healing the trauma of sexual abuse: A therapeutic 7-step self-help program for men and women, including how to choose a therapist and find a support group. New York: Random House.

Eysenck, H. J., & Eysenck, S. B. G. (1975). Manual of the Eysenck Personality Questionnaire. London: Hodder & Stoughton.

Faller, K. C. (1988). Child sexual abuse: An interdisciplinary manual for diagnosis, case management, and treatment. New York: Columbia University Press.

Finkelhor, D., & Lewis, I. A. (1988). An epidemiologic approach to the study of child molestation. In R. Prentky & V. Quinsey (Eds.), Human sexual aggression: Current perspectives (pp. 64-78). New York: Annals of the New York Academy of Sciences.

Forgac, G. F., & Michaels, E. J. (1982). Personality characteristics of two types of male exhibitionists. Journal of Abnormal Psychology, 91, 287-293.

Fosterling, F. (1988). Attribution theory in clinical psychology. Chichester, U.K.: John Wiley and Sons.

Friedman, S. (1991). Outpatient treatment of child molesters. Sarasota, FL: Professional Resource Exchange.

Frisbie, L. V., Vanasek, F. J., & Dingman, H. F. (1967). The self and the ideal self: Methodological study of pedophiles. Psychological Reports, 20, 699-706.

Fruehwald, S., Eher, R., Frottier, P., Aigner, M., Gutierrez, K., Dwyer, S. M. (1998). The relevance of self-concepts discriminating in long-term incarcerated sex offenders. Journal of Behavior Therapy and Experimental Psychiatry, 29, 267-278.

Furby, L., Weinrott, M. R., & Blackshaw, I. (1989). Sex offenders recidivism: A review. Psychological Bulletin, 105, 3-30.

Geer, J. H., Estupinan, L. A., & Manguno-Mire, G. M. (2000). Empathy, social skills, and other relevant cognitive processes in rapists and child molesters. Aggression and Violent Behavior, 5, 2000.

Gil, E. (1995). A guide for parents of children who molest. Rockville, MD: Launch Press.

Gil, E. (1983). Outgrowing the pain. Rockville, MD: Launch Press.

Gil, E., & Bodmer-Turner, J. B. (1994). Someone in my family has molested children. Rockville, MD: Launch Press.

Gordon, A., & Porporino, F. J. (No. B-05, May 1990). Managing the treatment of sex offenders. A Canadian Perspective. Retrieved May 19, 2001 from the World Wide Web: <http://www.csc-scc.gc.ca/text/rsrch/briefs/b5/b05e.shtml>.

Greenfeld, L. A. (1997). Sex offenses and offenders: An analysis of data on rape and sexual assault. (NCJ Rep. 163392). U.S. Department of Justice.

Grossman, L. S., Martis, M. & Fichtner, C. G. (1999). Are sex offenders treatable? A research overview. Psychiatric Services, 50, 349-361.

Hall, G. C. N. (1995). Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. Journal of Consulting and Clinical Psychology, 63, 802-809.

Hanson, R. K. (1997). How to know what works with sexual offenders. Sexual Abuse: A Journal of Research and Treatment, 9, 129-145.

Hanson, R. K., Steffy, R. A., & Gauthier, R. (1992). Long-term follow-up of child molesters: Risk predictors and treatment outcome. Retrieved April 21, 2001 from the World Wide Web: <http://www.sgc.gc.ca/epub/corr/e199202/e199292.htm>.

Harris, G. T., Rice, M. E., & Cromier, C. A. (1991). Psychopathy and violent recidivism. Law and Human Behavior, 15, 625-637.

Heider, F. (1958). The psychology of interpersonal relations. New York: John Wiley and Sons.

Holmes, E. P. & River, L. P. (1998). Individual strategies for coping with the stigma of severe mental illness. Cognitive and Behavioral Practice, 5, 231-239.

Horley, J., & Quinsey, V. L. (1994). Assessing the cognitions of child molesters: Use of the semantic differential with incarcerated offenders. Journal of Sex Research, 31, 171-178.

Horley, J., Quinsey, V. L., & Jones, S. (1997). Incarcerated child molesters' perceptions of themselves and others. Sexual Abuse: A Journal of Research and Treatment, 9, 43-55.

Jain, U., Blais, M. A., Otto, M. W., Hirshfeld, D. R., & Sachs, G. S. (1999). Five-factor personality traits in patients with seasonal depression: Treatment effects and comparisons with bipolar patients. Journal of Affective Disorders, 55, 51-54.

Johnston, L., & Ward, T. (1996). Social cognition and sexual offending: A theoretical framework. Sexual Abuse: A Journal of Research and Treatment, 8, 55-80.

Knight, R. A., Carter, D. L., & Prentky, R. A. (1989). A system for the classification of child molesters: Reliability and application. Journal of Interpersonal Violence, 4, 3-23.

Langevin, R., & Lang, R. (1985). Psychological treatment of pedophiles. Behavioral Sciences and the Law, 3, 403-419.

Lannoo, E., DeDeyne, C., Colardyn, F., De Soete, G., & Jannes, C. (1997). Personality change following head injury: Assessment with the NEO five-factor inventory. Journal of Psychosomatic Research, 43, 505-511.

Lehne, G. (1994). The NEO-PI and the MCMI in the forensic evaluation of sex offenders. In P. Costa & T. A. Widiger (Eds.), Personality disorders and the five-factor model of personality (pp. 175-188). Washington, D.C.: American Psychological Association.

Levin, S. L., & Stava, L. (1987). Personality characteristics of sex offenders: A review. Archives of Sexual Behavior, 16, 57-79.

Maletzky, B. M. (1991). Treating the sexual offender. Newbury Park, CA: Sage.

Marques, J. K., Day, D. M., Nelson, C., & West, M. A. (1994). Effects of cognitive behavioral treatment on sex offender recidivism: Preliminary results of a longitudinal study. Criminal Justice and Behavior, 21, 28-54.

Marshall, W. L. (1994). Treatment effects on denial and minimization in incarcerated sex offenders. Behaviour Research and Therapy, 32, 559-564.

- Marshall, W. L., Jones, R., Ward, T., Johnston, P., & Barbaree, H. E. (1991). Treatment outcome with sex offenders. Clinical Psychology Review, 11, 465-485.
- Marshall, W. L. & Pithers, W. D. (1994). A reconsideration of treatment outcome with sex offenders. Criminal Justice and Behavior, 21, 10-27.
- McCormick, R. A., Dowd, E. T., Quirk, S., & Hernando-Zegerra, J. (1998). The relationship of NEO-PI performance to coping styles, patterns of use, and triggers for use among substance abusers. Addictive Behaviors, 23, 497-507.
- Mirels, H. L., Stevens, F., Greblo, P., & Yurek, D. L. (1998). Differentiation in personality descriptions of the self and others. Personality and Individual Differences, 25, 663-681.
- Murphy, W. D. (1990). Assessment and modification of cognitive distortions in sex offenders. In W. L. Marshall, D.R. Laws, & H.E. Barbaree (Eds.), Handbook of sexual assault: issues, theories, and treatment of the offender (pp. 331-342). New York: Plenum Press.
- Muten, E. (1991). Self-reports, spouse ratings, and psychophysiological assessment in a behavioral medicine program: An application of the five-factor model. Journal of Personality Assessment, 57, 449-464.
- Nichols, H. R., & Molinder, M. A. (1984). Multiphasic Sex Inventory Manual (Available from the authors, 437 Bowen Drive, Tacoma, WA 98466).
- Nisbett, R. E., Caputo, C., Legant, P., & Maracek, J. (1973). Behavior as seen by the observer. Journal of Personality and Social Psychology, 27, 154-164.

Nugent, P. M., & Kroner, D. G. (1996). Denial, response styles, and admittance of offenses among child molesters and rapists. Journal of Interpersonal Violence, 11, 475-486.

Olson, B. D., & Suls, J. (2000). Self, other, and ideal-judgments of risk and caution as a function of the five-factor model of personality. Personality and Individual Differences, 28, 425-436.

Osgood, C. E., Suci, G. J., & Tannenbaum, P. H. (1957). The measurement of meaning. Urbana: University of Illinois Press.

Ottomanelli, L. A. (1995). Predicting relapse among substance abusers as a function of personality dimensions. (Doctoral dissertation, Texas Tech University, 1995). Dissertation Abstracts International: Section B, The Sciences and Engineering, 55(7-B): 3052.

Overholser, J. C., & Beck, S. (1986). Multimethod assessment of rapists, child molesters, and three control groups on behavioral and psychological measures. Journal of Consulting and Clinical Psychology, 54, 682-687.

Piedmont, R. L., & Ciarrocchi, J. W. (1999). The utility of the revised NEO personality inventory in an outpatient, drug rehabilitation context. Psychology of Addictive Behaviors, 13, 213-226.

Pithers, W. D. (1994). Process evaluation of a group therapy component designed to enhance sex offenders' empathy for sexual abuse survivors. Behavior Research and Therapy, 32, 566-570.

Pollack, N. L., & Hashmall, J. M. (1991). The excuses of child molesters. Behavioral Sciences and the Law, 9, 53-59.

Prentky, R. A., & Foley, T. P. (1999, December 30). Terminology. Retrieved December, 20, 1999 from the World Wide Web: <http://www.forensicexaminers.com/terminology.html>

Prentky, R. A., Knight, R. A., & Lee, A. F. S. (1997). Child sexual molestation: Research issues. (NCJ Rep. 163390). Washington, D.C.: National Institute of Justice.

Pressor, L., & Gunnison, E. (1999). Strange bedfellows: Is sex offender notification a form of community justice? Crime and Delinquency, 45, 299-315.

Pribyl, D. S. (1998). The child sex offenders' perspective on treatment and related factors. Dissertations Abstracts International: Section B: The Sciences and Engineering, 58(10B), 5653.

Rice, M. E., Quinsey, V. L., & Harris, G. T. (1991). Sexual recidivism among child molesters released from a maximum security psychiatric institution. Journal of Consulting and Clinical Psychology, 59, 381-386.

Sadoff, R. L., Roether, H. A., & Peters, J. J. (1971). Clinical measure of enforced group psychotherapy. American Journal of Psychiatry, 128, 116-119.

Sanderson, C., & Clarkin, J. F. (1994). Use of the NEO-PI personality dimensions in differential treatment planning. In P. Costa & T. A. Widiger (Eds.), Personality disorders and the five-factor model of personality (pp. 59-71). Washington, D.C.: American Psychological Association.

Seto, M. C., & Barbaree, H. E. (1999). Psychopathy, treatment behavior, and sex offender recidivism. Journal of Interpersonal Violence, 14, 1235-1248.

Sewell, K. W., & Salekin, R. T. (1997). Understanding and detecting dissimulation in sex offenders. In R. Rogers (Ed.), Clinical Assessment of Malingering and Deception (pp.328-350). New York: The Guilford Press.

Smallbone, S. W., & Dadds, M. R. (1998). Childhood attachment and adult attachment in incarcerated adult male sex offenders. Journal of Interpersonal Violence, 13, 555-573.

Smuckler, A. J., & Schiebel, D. (1975). Personality characteristics of exhibitionists. Diseases of the Nervous System, 36, 600-603.

Stein, M. B., & Hackerman, F. R. (1991). The use of the MMPI-2 in conjunction with the NEO personality inventory. Psychological Reports, 69, 955-958.

Stermac, L. E., & Segal, Z. V. (1989). Adult sexual contact with children: An examination of cognitive factors. Behavior Therapy, 20, 573-584.

Storms, M. (1973). Videotape and the attributional process: Reversing actors' and observers' points of view. Journal of Personality and Social Psychology, 27, 165-175.

Studying Personality. Retrieved June 4, 2001 from the Word Wide Web:
<http://peace.saumag.edu/faculty/Kardas/Courses/GPWeiten/C12Personality/StudPers/html>
1

Stop it Now (1999, December). Answers to commonly asked questions about child sexual abuse. Retrieved December, 24, 1999 from the World Wide Web:
<http://stopitnow.com/answers.html>

Trull, T. J., & McCrae, R. R. (1990). The five-factor perspective on personality disorder research. In P. Costa & T. A. Widiger (Eds.), Personality disorders and the five-factor model of personality (pp. 59-71). Washington, D.C.: American Psychological

Association.

Trull, T. J., & Widiger, T.A. (1997). Structured Interview for the Five Factor Model of Personality (SIFFM): Professional manual. Odessa, FL: Psychological Assessment Resources.

Velting, D. M. (1999). Personality and negative expectancies: Traits structure of the beck hopelessness scale. Personality and Individual Differences, 26, 913-921.

Ward, T., Hudson, S. M., & Johnston, L. (1997). Cognitive distortions in sex offenders: An integrative review. Clinical Psychology Review, 17, 497-507.

Ward, T., McCormack, J., & Hudson, S. M. (1997). Sexual offenders' perceptions of their intimate relationships. Sexual Abuse: A Journal of Research and Treatment, 9, 57-74.

Watson, D., & Clark, L. A. (1984). Negative affectivity: the disposition to experience aversive emotional states. Psychological Bulletin, 96, 465-490.

Weeks, J. R., Pelletier, G., & Beaudette, D. (1995). Correctional officers: How do they perceive sex offenders? International Journal of Offender Therapy and Comparative Criminology, 39, 55-61.

Wilson, G. D., & Cox, D. N. (1983). Personality of paedophile club members. Personality and Individual Differences, 4, 323-329.

Yochelson, S., & Samenow, S. E. (1977). The criminal personality. Vol. II: The change processes. New York: Jason Aronson.